New Zealand's choice: Funding our drug policy

A New Zealand drug budget compared to public perspectives and willingness to pay

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Important note: This is the full report, which includes the details of all the methods used, including data sources and assumptions made for the drug budget. A summary version of the report is also available at https://helenclark.foundation/publications/ or https://ourarchive.otago.ac.nz/esploro/

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Foreword

The prohibitionist basis of New Zealand's response to illegal drug use was developed in the 1960s and 1970s. Much has changed since then, and there is significant and growing evidence that enforcement is not an effective approach to reducing harm from drug use in our communities. There has been some law reform, for example to legalise testing of drugs bought on the illegal market, and to encourage the police to divert those in possession of illicit drugs to services.

The research underlying this report suggests that the public want to see more investment in non-enforcement approaches. Its findings encourage the design of more humane, evidence-based, and cost-effective responses to drug use.

The results of this research are heartening for all New Zealanders who want to reduce the harm caused by prohibitionist policy which inhibits effective harm reduction. The report presents a timely opportunity to review New Zealand's approach to drugs.

Those who participated in deliberative conversations about drug policy for this project grappled with complex policy issues, and arrived at nuanced, workable, and politically realistic proposals. This reinforces the potential for deliberative democracy processes to build consensus and legitimacy around new approaches to policy challenges, even on sensitive issues like drug use.

I commend this report to politicians, policymakers, communities, and to every New Zealander who believes that a more effective response to drug use which puts people's health and human rights at its heart is possible.

Helen Clark

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I am grateful to all those who have supported this project. The Helen Clark Foundation interns; Pieta Bouma, Oliver Winter, and Anna Doak, who provided research support. Staff from NZ Police, Customs, Ministry of Health, Te Whatu Ora, KnowYourStuff NZ, and the NZ Drug Foundation for activity checking and validation of information for the drug budget. Professor Alison Ritter and Dr Paul Kelaita from the University of New South Wales, who provided guidance on the drug budget. The team from Talbot Mills Research for supporting the polling. Daisy Penfold for her research in the New Zealand archives. The Riccarton U3A for supporting the deliberative workshops, and particularly the 10 members who volunteered to be part of the group. Professor Joe Boden (University of Otago), Professor Doug Sellman (University of Otago), Jason George (DISC Trust), and Detective Senior Sergeant Phil Sparks (NZ Police) for being guest speakers at the deliberative workshops. Kali Mercier from the Helen Clark Foundation for her peer review.

Rose Crossin

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Executive summary

Drugs are a long-standing health, social, economic, and policy issue in New Zealand. Drug use continues to rise, despite largely prohibition-based policy settings. Drug use remains a 'wicked problem', as it is complex, stigmatised, and has strong moral and value judgements attached to it. Responding fairly and effectively to drug use and harm therefore remains challenging.

Significant policy inertia exists in New Zealand, and there is an apparent unwillingness for many politicians to engage in this debate, potentially due to concerns about community or electoral backlash. But, given that the Government spends nearly half a billion dollars each year responding to drug use, and that the total cost of drug harm to New Zealand is estimated at nearly $2 billion per year, it is essential that our policy settings are aligned with the evidence and best practice.

Policy interventions to respond to the issues of drugs are often described using the 'four-pillars' model:

- **Law enforcement or supply reduction:** actions intended to reduce the availability of drugs, e.g. customs, policing, and criminal justice processes.
- **Prevention:** actions intended to prevent people from starting using drugs, e.g. through early intervention or education.
- **Treatment:** reducing demand among those already using drugs (through treatment for use disorders).
- **Harm reduction:** strategies aimed at reducing negative consequences associated with drug use, e.g. provision of sterile injecting equipment, or drug-checking, or provision of naloxone (a medicine used to reverse opioid overdoses).

Faced with an increasing and more volatile global drug supply, the efficacy of the prohibition model is being challenged, and new drug policy settings are being trialled internationally. Both the evidence and public opinion on the best way to respond to drug use and harm have evolved, with health-based approaches that emphasise prevention, treatment and harm reduction alongside supply reduction becoming increasingly used. To help inform an overdue update of New Zealand's drug policy settings, it is important to be aware of public opinion on these issues.

The aims of this project were, therefore, to understand the views of New Zealanders on how the Government funds responses to illegal drugs, by:

1. providing an estimate of how money is currently allocated to different areas of drug policy in New Zealand (the 'drug budget')
2. finding out the preferred funding allocation ('willingness to pay') from a representative community sample
3. using a 'deliberative workshop' method, with a group of citizens, to test the value of deliberative democratic processes for drug policy.

The research found that law enforcement receives 68.2 per cent of drug policy funding, with treatment receiving 24.8 per cent, prevention receiving 5.5 per cent, and harm reduction receiving 1.4 per cent. The total amount of money spent proactively responding to illegal drugs in New Zealand in 2022/23 is estimated as $489,468,763. This represents 0.3 per cent of total crown expenditure in that year, and a per-person spend of $95.

This can be compared to Australia in 2021/22, which had an estimated spend of $5.45 billion, equivalent to 0.6 per cent of government expenditure and a per-person spend of $210. In Australia, funding proportions were; 64.3 per cent to law enforcement; 27.4 per cent to treatment, 6.7 per cent to prevention, and 1.6 per cent to harm reduction. While the proportions of funding in Australia are similar to New Zealand, the overall amount of funding is significantly higher in Australia.

In contrast to actual spending, when a representative sample of New Zealand citizens was asked how they would like $100 of their tax spent responding to illegal drugs, they wanted significantly more spent on prevention and harm reduction, and proportionally less spent on law enforcement (see Figure 1 below).

Community preferences allocate almost two-thirds of funding towards a health-based approach to drugs (collectively: treatment, prevention, harm reduction). This shows that the New Zealand community want more investment in these areas of drug policy.

Notably, there is strong and consistent support for increased spending on prevention across all demographic groups, irrespective of political preferences. This presents a clear opportunity for cross-party consensus on a more effective response.

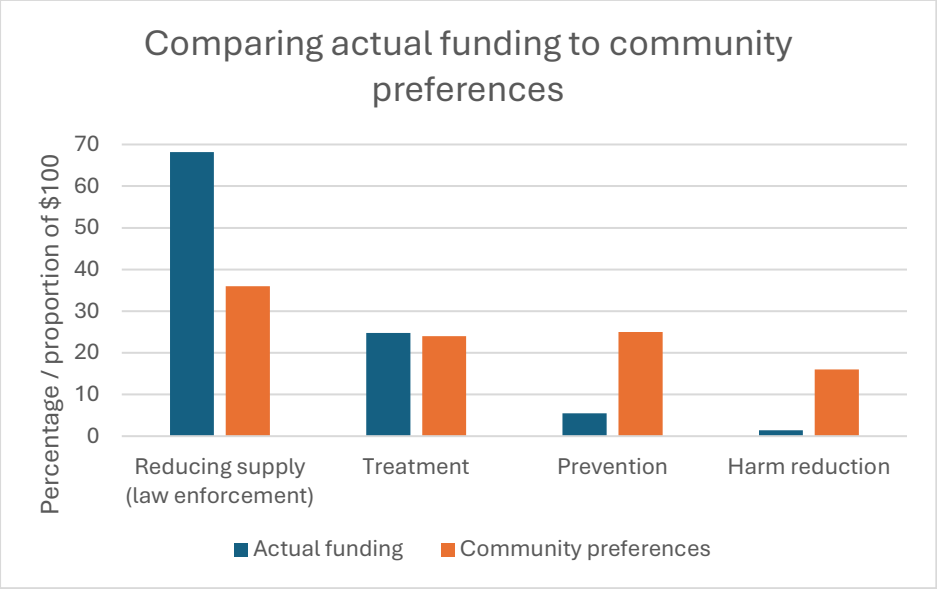

Figure 1 – actual funding (as a percentage) compared to community preferences for funding allocation (as a hypothetical $100 of tax)

Historical analysis of New Zealand's drug policy settings dating back to the 1960s demonstrates that the will and preferences of New Zealander's have not been reflected in our drug laws. There have been multiple reviews recommending that the Misuse of Drugs Act 1975 be repealed and replaced with a health-based approach to drugs.

Internationally, deliberative democratic processes, such as Citizen's Assemblies, are increasingly used for complex policy issues, including drug policy. These processes improve democratic participation and are intended to ensure the will of the people is reflected in Government policy. This research trialled a deliberative group learning process with a group of citizens in Christchurch, who then produced a consensus statement, which strongly supported a health-based approach to drugs. This serves as a promising example of what could be achieved in New Zealand using deliberative democracy for drug policy reform.

The conclusion reached through all three phases of this research is that there is a significant gap between current funding allocations and community preferences. This research clearly shows the views of the New Zealand community are significantly closer to a health-based approach to drugs than what might be currently perceived by politicians and policymakers. Therefore, there is an opportunity for our politicians to follow the evidence and move towards a health-based approach to drugs. Crucially, this research shows they would be supported by the community in doing so.

Recommendations

This report makes four recommendations to improve drug policy in New Zealand. These recommendations acknowledge that treatment, prevention, and harm reduction require additional funding, but that both prevention and harm reduction would also benefit from an integrated and systems-level approach, as well as from additional funding.

Recommendation 1: Immediately increase the funding for prevention, treatment, and harm reduction in New Zealand, in line with stated community preferences.

Recommendation 2: In line with stated community preferences, the Government should develop, implement, and comprehensively fund an evidence-based drug prevention programme for New Zealand. This should take a systems approach and include interventions that are specific to drugs, as well as investment in universal interventions that strengthen individuals and communities, by acting on determinants of health such as poverty and poor mental health.

Recommendation 3: In line with stated community preferences, the Government should develop, implement, and comprehensively fund an evidence-based harm reduction programme for New Zealand. This should be done by expanding existing harm reduction services and funding new harm reduction services to create an integrated system.

Recommendation 4: That a citizens' assembly on the issue of illegal drugs be held in New Zealand, consistent with the conclusion reached during the deliberative workshops that were held. Planning for this should begin immediately, with a commitment to holding an assembly within the next two years. The citizens' assembly should be given a broad mandate to consider drug laws, policies, and funding allocations at a systems level. This should be funded by the Government. The objective would be to seek cross-party commitment to act on the findings and recommendations that arise from this deliberative democratic process.

Introduction to drugs in New Zealand

Psychoactive drugs are substances that are ingested in order to alter mood, consciousness, and/or behaviour. For the purpose of this report, the term 'drugs' is used to refer to those that are illegal and controlled under the Misuse of Drugs Act 1975 (therefore excluding alcohol and tobacco), for example, cannabis, methamphetamine, cocaine, or MDMA ('ecstasy')[1].

Current drug policy settings

The primary piece of legislation in New Zealand that aims to regulate and prevent the misuse of classified drugs is the Misuse of Drugs Act 1975 and its associated regulations. New Zealand also has the Psychoactive Substances Act 2013, which was intended to provide a legal and regulated supply of approved psychoactive substances, though no products have been, or currently are, approved.

Policy interventions to respond to the issues of drugs are often described using the a 'four-pillars' model to describe the different types of interventions:

- **Law enforcement or supply reduction:** actions intended to reduce the availability of drugs, e.g. customs, policing, and criminal justice processes.
- **Prevention:** actions intended to prevent people from starting using drugs, e.g. through early intervention or education.
- **Treatment:** reducing demand among those already using drugs (through treatment for use disorders).
- **Harm reduction:** strategies aimed at reducing negative consequences associated with drug use, e.g. provision of sterile injecting equipment, or drug-checking, or provision of naloxone (a medicine used to reverse opioid overdoses).

Some jurisdictions also use a 'three-pillar' model, which combines prevention and treatment into a single pillar called 'demand reduction'. The four-pillar model has been chosen for this report, as it provides more specific insights into people's perspectives and preferences.

New Zealand does not currently have a National Drug Strategy. The most recent strategy was dated 2015–2020, and included alcohol within its scope, but not tobacco (Ministry of Health, 2015). The overarching goal of the strategy was to "Minimise alcohol and other drug-related harm and promote and protect health and wellbeing". Strategies were organised under three areas:

1. Problem limitation – barriers to people accessing and receiving support or treatment for their own or others' AOD (alcohol and other drug) use are removed.
2. Demand reduction – people have the knowledge, skills, and support to make good decisions about their AOD use.
3. Supply reduction – access to AOD for harmful use is minimised.

It is notable that the most recent New Zealand strategy does not include harm reduction as a defined and standalone strategic area, but instead, harm reduction is included within 'problem limitation'.

New Zealand currently aims to control drug use through a largely prohibition/criminalisation approach, where those who are caught in possession of, or are supplying or trafficking drugs, are

[1] In justice-related datasets, these are referred to as 'illicit drugs', therefore, the terms illegal and illicit drugs are both used throughout.

subject to legal penalties. New Zealand has not decriminalised drug use or possession, though in 2019 there was an amendment to the Misuse of Drugs Act, which affirmed that Police have discretion over whether to prosecute for personal possession of drugs. Instead, they can choose to take a 'health-based approach'.

The New Zealand government funds drug treatment services through the public healthcare system, as well as some funding for prevention programmes, e.g. early family support. New Zealand also has some provision for legal harm reduction services, for example, sterile injecting equipment can be legally procured through needle exchanges and participating pharmacies, and drug-checking was legalised in 2021 by the passing of the Drug and Substance Checking Legislation Act.

Drug use

Despite their illegal status and the potential for criminal penalties, many New Zealanders use, or have used, drugs. From the 2023/24 *Drug Use in Aotearoa* report, 15.6 per cent of New Zealanders aged 15 or over report using cannabis in the last year, equating to approximately 675,000 people. Additionally, 4.8 per cent report using MDMA in the past year, 2.4 per cent cocaine, 1.3 per cent methamphetamine, and 1.2 per cent opioids. Rates of use of all drugs reported are either stable or increasing. The price of illegal drugs is decreasing, and wastewater testing shows that the overall quantity of use is increasing. In particular, the quantity of methamphetamine and cocaine detected in wastewater has increased by 74 per cent and 229 per cent respectively, when compared to the average from the prior three years (New Zealand Drug Foundation, 2025).

New Zealand's drug market is largely from supply imported via international trafficking, with the exception of cannabis, where there is still significant domestic production. There is also some domestic manufacture of methamphetamine, as well as importation. Customs data shows that total drug seizures have steadily risen over time, with over 1,000 seizures in Q4 2024 (New Zealand Customs Service, 2025). These trends reflect the global drug supply, with the 2025 United Nations Office on Drugs and Crime World Drug Report confirming that drug supply globally remains high and, in particular, the cocaine market (including markers of both production and use) continues to rise rapidly internationally. Synthetic opioids continue to cause harm globally, particularly nitazenes, which have been associated with an increasing number of deaths (largely when used inadvertently after being sold as other drugs). The report also highlights the impact of illegal drug trade through violence and instability associated with the black market and organised crime, and that the global drug trade generates hundreds of billions of dollars annually (United Nations Office on Drugs and Crime, 2025).

Drug harm

Drug use can result in harm, both to the individual who uses drugs and to others (Crossin et al., 2023). It is important to note though that not all drug use results in harm. The 2023 New Zealand Drug Harm Index conservatively estimated that drug harm in New Zealand costs an estimated $1.9B per year (National Drug Intelligence Bureau, 2024). Harm can arise from both the drug itself and from drug policy settings.

When considering harm to the person using the drug, this may include health harms such overdose deaths or drug-related health issues, psychological harms including dependence or impaired mental health, and social harm such as loss of employment, impact on finances, and damage to relationships. For example, in 2023, 188 people died of an unintentional drug overdose (New Zealand Drug Foundation, 2024), and almost 50,000 New Zealanders accessed addiction

treatment services (Mental Health and Wellbeing Commission, 2025). Furthermore, in 2024, there were over 8,000 criminal charges finalised for adults for illicit drug offences; over 3,000 of those were for possession (Stats NZ, 2025). Possessing an illegal drug is in itself a criminal offence; there is no requirement on the Police to prove that harm has occurred through that drug use. Many commentators have pointed out that receiving a criminal conviction for drug use can itself cause long-term harm, such as loss of employment and economic opportunities.

Drug harm can also impact others, including family and friends of the person using drugs, and the wider community. For example, drugs are detected in the driver in almost a third of fatal traffic crashes in New Zealand (NZ Transport Agency, 2025). There is also crime and violence associated with organised crime in New Zealand, which results from the drug trade, and impacts individuals and communities.

Rationale and aims

Drug use in New Zealand continues to rise, despite largely prohibition-based policy settings, and is reflective of a high global drug supply. Drug use and policy remain a 'wicked problem', as they are complex, intertwined with multiple determinants of health, stigmatised, and have strong moral and value judgements attached to them. Significant policy inertia exists in New Zealand, and there is an apparent unwillingness for many politicians to engage in this debate, potentially due to concerns about community or electoral backlash. Nevertheless, a significant amount of Government expenditure is spent responding to drugs.

'Drug budgets' are a method for estimating public expenditure on drugs, and the European Monitoring Centre for Drugs and Drug Addiction has published a 2008 framework to guide jurisdictions on how to conduct these estimates (European Monitoring Centre for Drugs and Drug Addiction, 2008). 'Drug budgets' do not cover whether government investment represents effective intervention, value for money, or an appropriate response to drug use, drug supply, and drug-related harm. Rather, they are indicative of current funding arrangements and spending priorities, and an indicator of what the Government considers important. Australia has recently conducted and updated their 'drug budget' and the following excerpt highlights key messages from this report (Ritter et al., 2024):

> Australian governments spent approximately $5.45 billion in 2021/22 in proactive responses to illicit drugs. The $5.45 billion amounts to 0.63% of government expenditure. In 2021/22, this represented a per person spend of $209.61. This analysis concerns proactive spending only – the provision of policing, harm reduction, treatment, and prevention services aimed at reducing drug use and associated harms.

When considering spending against the 'four pillars' of drug policy, the proportions and total spending allocated in Australia were; law enforcement (64.3 per cent, $3,506,017,286), prevention (6.7 percent, $362,711,455), treatment (27.4%, $1,491,306,732), and harm reduction (1.6%, $89,897,540). Total expenditure was estimated as $5,449,933,013.

Separate to the drug budget, Australia also collects data in a national survey on people's preferred allocation of resources across three of the four drug policy pillars (the question excludes harm reduction). The latest Australian National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2024) asked respondents about the distribution of a hypothetical $100.00 across three of the four domains covered in their 'drug budget'. In 2022/23,

Australians wanted $36.50 spent on drug education, $32.00 spent on drug treatment, and $31.50 spent on law enforcement responses to illicit drugs. While there are no data to understand funding preferences for harm reduction, this broadly suggests that Australians have a preference for government investment to be similar across policy domains relating to illegal drugs.

Among drug policy experts, there is a strong understanding that the issues in drug policy are not due to evidence gaps, as there is good evidence about what does and does not work to reduce harm. It is more an issue of political decision making, which has seen current policy settings maintained largely unchanged for decades. Therefore, understanding community preferences is useful. Importantly, though, New Zealand has no equivalent data to Australia on either funding allocation or community preferences on funding allocations.

There are a number of reasons why this is important for New Zealand currently. Global drug supply is increasing and becoming more volatile. While New Zealand has not yet experienced a significant incursion of synthetic opioids, similar to what has been seen in North America and implicated in rising unintentional overdose deaths, it appears inevitable this will occur at some point. All areas of New Zealand's drug policy need to be prepared for this eventuality, including prevention and harm reduction systems and services. In the face of this changing drug supply, there are calls globally for the prohibition model to be rethought, and countries internationally are trialling new drug policy settings, including both decriminalisation and legal regulation (legalisation).

The aims of this project were to understand the views of New Zealanders on how the Government funds responses to illegal drugs, by:

1. providing a preliminary estimate of the allocation of drug policy funding in New Zealand between the four drug policy pillars (the 'drug budget')
2. determining whether the current allocation is consistent with the preferred funding allocation ('willingness to pay') from a representative community sample
3. using a 'deliberative workshop' method, along with pre-post surveys, among a group of citizens, in order to:
    a. assess whether individuals' views change on 'willingness to pay' for drug policy options following a deliberative group learning process
    b. determine whether a group of citizens can reach a consensus on 'willingness to pay' following a deliberative group learning process
    c. qualitatively understand how group members' views were or were not influenced by the deliberative group learning process, and which (if any) of the activities group members thought most influenced their final views.

How money is currently spent: The 'drug budget'

Important notes on interpretation and scope

There are limitations and uncertainties associated with all expenditure estimates, as documented in the Methods section. Therefore, it is important to note that the proportion of expenditure between the policy domains is more important than the absolute expenditure figures.

The estimates in this report are of how public funding is currently being spent; this does not seek, or claim, to answer whether this expenditure represents value for money, or whether initiatives receiving funding are effective at minimising drug-related harm. The currently funded activities do not necessarily represent what would be funded in an 'ideal world'.

This report only includes proactive spending, i.e. activities that have a clear objective of reducing drug use or problems (Godfrey et al., 2002). It does not include reactive spending, which would include the costs of the consequences of drug use (e.g. healthcare costs spent responding to drug-related accidents are excluded, as are law enforcement costs of drug-related violence).

As such, this does not represent the total cost of drugs or drug harm to New Zealand. This could be done through a social cost study, which may be more akin to the New Zealand Drug Harm Index. The 2024 version of the index estimated that drugs cost New Zealand $1.9 billion annually, which is a conservative estimate, but provides costs related to loss of life and drug-related hospital admissions (National Drug Intelligence Bureau, 2024). Another valuable approach would be to do a cost-effectiveness study, in order to determine the outcomes of programmes, relative to investment.

The scope for the drug budget extends only to drugs that are prohibited under the Misuse of Drugs Act 1975. Alcohol and tobacco are therefore excluded. The reference year used was 2022/23, to allow time for reporting to be completed allowing this research to draw on the most complete data available. Selecting this reference year was preferable over earlier years to minimise any potential COVID-19 pandemic effects that might have skewed data from 2020/21.

The intention of developing this 'drug budget' was to provide a point of comparison between actual spending and public preferences for funding allocations. These estimates could also be used as a baseline, to assess change in funding allocations over time.

Total funding allocation

The total amount of money spent proactively responding to illegal drugs in New Zealand in 2022/23 is estimated as $489,468,763. To contextualise this figure, it represents 0.3 per cent of total crown expenditure in that year and a per-person spend of $95 (New Zealand Government, 2023; Stats NZ, n.d.b). This money was split between the four drug policy pillars as per Table 1.

Table 1 – Total proactive expenditure on drugs

POLICY DOMAIN	FUNDING IN 2022/23	PERCENTAGE
Law enforcement (supply reduction)	$334,013,805	68.2%
Treatment	$121,557,989	24.8%
Prevention	$26,994,593	5.5%
Harm reduction	$6,902,376	1.4%
Total – proactive spending on illegal drugs	**$489,468,763**	**100%**

Reducing supply/law enforcement

Activities under this domain are intended to reduce the availability and/or accessibility of illegal drugs, through reduction in drug supply and law enforcement. This domain includes customs, policing, justice-related costs, and corrections. Law enforcement activities are estimated to cost a total of $334,013,805 (Table 2).

Table 2 – Law enforcement (supply reduction) funding

ACTIVITY	FUNDING IN 2022/23
Customs and border control	$30,917,075
Routine policing	$116,201,414
Court prosecutions	$23,959,976
Legal expenses	$24,318,580
Corrective services	$120,189,240
Community corrections	$18,427,520
Total – law enforcement domain	**$334,013,805**

Customs and border control

This sub-domain attempts to calculate the proportion of the total relevant budget dedicated to reducing the supply of illicit drugs into New Zealand through customs and border control.

The relevant appropriations identified in Budget 2022's Vote Customs is $111,145,000 for services relating to goods crossing borders, and $88,320,000 for services relating to travellers crossing borders (Treasury, 2022c). Capital expenditure, the collection of crown revenue and provision of services to other ministries, was excluded. The final figure is thus $199,465,000.

It is noted that the 2023 Customs Annual Report identifies slightly more expenditure for services relating to goods ($113.5 million) and slightly less for travellers ($86.9 million), ultimately arriving at a sum figure slightly larger than the Vote Customs figure ($200.4 million) (NZ Customs Service, 2023). For the sake of consistency with other sub-domains, the Budget 2022 figure is used for this calculation.

It is difficult to determine how much of customs time is dedicated to detection of illegal drugs. The Australian drug budget report uses updated figures from a 2005 calculation that estimates Australian border control on illicit drugs from US figures, concluding that 17.43 per cent of customs border activity is related to illicit drug activity (Ritter et al., 2024). There are a number of limitations discussed in relation to this calculation, particularly the applicability of the US context to Australia. This number was validated for this report by comparing illegal drug interceptions in New Zealand to the number of physical examinations of baggage or parcels (New Zealand Customs Service, n.d.):

- In 2022/23 there were 8,618 physical baggage searches and 1,141 illicit drug interceptions at airports (13.2 per cent)
- In 2022/23 there were 9,388 mail items physical examined and 1,671 illicit drug interceptions at mail centres (17.8 per cent).

Neither are orders of magnitude different to the Australian proportion, but the midpoint of 15.5 per cent was used and applied to the total customs expenditure. This results in a total for customs and border control of $30,917,075 (15.5 per cent of $199,465,000).

Routine policing

This sub-domain estimates the proportion of police time that is allocated to illegal drugs, by calculating time on the basis of composition of arrests. This will include detection, arrest, and charging of drug offences (including possession and supply), and specialist activities such as cannabis recovery operations and district drug squads. This has been apportioned using a top-down approach, due to difficulties in costing the time of routine activities. A limitation of the top-down approach is that it assumes that different types of offences take the same amount of time to detect and process.

There are challenges in that some police activities may plausibly fit under more than one 'pillar'. For example, the 'High Alert' drug early warning system provides rapid knowledge on dangerous drugs that may be circulating in New Zealand. This programme could be considered both policing and harm reduction. It was considered that the Resilience to Organised Crime in Communities programme fit better into the Prevention domain; therefore, its costs were included there, and then deducted from the Routine Policing total, to avoid double-counting. Some specialist drug operations are able to be costed at a programme level, and details of these are provided in Appendix 1, which could be used to build some bottom-up cost estimates.

Vote Police from Budget 2022 apportioned $774,168,000 for investigations, $589,229,000 for primary response management, $508,340,000 for crime prevention services, and $427,831,000 for Road Safety (Treasury, 2022h). Road Safety expenditure is included based on the fact the total proceedings figure, and thus the final percentage, includes recorded traffic proceedings. Also included was $100,000 for the United Nations Drug Control Programme contribution. Excluded is capital expenditure (almost $102 million), arms safety and control (over $44 million), policy advice and ministerial services (over $10 million), and search and rescue activities (over $1 million) (Treasury 2022h). The final estimated total expenditure figure is therefore $2,299,668,000.

From 1 April 2022 to 31 March 2023 there were 120,788 police proceedings, of which 6,221 were counted as Illicit Drug Offences in the ANZSOC Division (NZ Police, n.d.). This is 5.2 per cent of the total proceedings; therefore, routine policing is estimated to cost $117,283,068 (5.2 per cent of $2,299,668,000), from which the total for Resilience to Organised Crime in Communities is subtracted (see Appendix 1), for a final total of $116,201,414.

Court prosecutions

This sub-domain seeks to identify what proportion of expenditure on court prosecutions is related to illegal drugs. Due to a lack of information about average trial length, the top-down methodology used by the Australian drug budget is not available to this report. Instead, a bottom-up calculation was conducted, as described in the appendix of the Australian drug budget (Ritter et al., 2024). This is the cost-per-finalisation method, where the total recurrent expenditure is divided by the total number of finalisations in order to calculate the cost per finalisation. The amount of finalisations relevant to drug offences is then multiplied by this cost per finalisations.

Vote Courts appropriates $727,687,000 for services and salaries related to the district (including the Alcohol and other Drug treatment courts) and senior courts (Treasury, 2022b). Excluded from this calculation are the costs associated with tribunals, land courts, justices of the peace, and coroners.

Finalised charge data are available in calendar year, not financial year; therefore, these were averaged to calculate the overall proportion for 2022/23. The total number of charges finalised for adults in court was 60,065 in 2022 of which 2,087 were due to drug offences as the most serious offence, and in 2023 the total was 63,103 of which 2,052 were drug offences (Stats NZ, n.d.a). The total number of charges finalised for young offenders in 2022 was 1,416, of which nine were drug offences, and in 2023 the total was 1,668 of which nine were drug offences (Stats NZ, n.d.a). In total, the average number of finalised offences for 2022/23 was 63,126 with 2,079 for drug offences. This is 3.3 per cent of total court finalisations for drug finalisations as the most serious offence.

The cost-per-finalisation was $11,528. The cost of finalised court prosecutions for drug offences was therefore $23,959,976.

Legal expenses

This sub-domain seeks to identify what proportion of expenditure on legal expenses (e.g. procurement of legal aid services and public prosecution services) is related to illegal drugs. Vote Justice appropriates $75,689,000 for public defence services and the administration of legal services, $281,846,000 for the purchasing of legal aid services from other providers, and $16,597,000 for community legal assistance services (Treasury, 2022f). Excluded was funding for the provision of justice policy advice, the Justice and Emergency Agencies Property and Shared Services, capital expenditure, services from the Electoral Commission, advice and promotion services for various specialist commissions and authorities, and other expenses (Treasury, 2022f). The final estimated total expenditure figure is $374,132,000.

Rather than taking the 3.3 per cent of court finalisations with an illegal drug offense as the most serious offence, it was more appropriate to find the proportion of total offences that are drug offences. Legal expenses may incorporate more than the most serious charge in court finalisations, as individuals with multiple charges may access resources for those drug offences, as well as their most serious offence. Finalised charge data are available in calendar year, not financial year; therefore, these were averaged to calculate the overall proportion for 2022/23 (Ministry of Justice, 2025). There were 183,468 total charges finalised in 2022 and 207,747 in 2023. Of these, 12,640 were drug charges in 2022 and 12,597 in 2023. This is 6.5 per cent of all charges. This results in a final estimated expenditure for legal expenses of $24,318,580.

Corrective services

This sub-domain identifies the proportion of people in prison-based custodial services (both remand and sentenced) for illegal drug offences, as a proportion of total prison expenditure. In 2022/23, $1,282,200,000 was allocated for prison-based custodial services and $387,095,000 for rehabilitation interventions and services, for a total of $1,669,295,000 (Treasury 2022a). This excludes community corrections (calculated below), as well as policy advice, information provision, and Ministerial services.

In 2022/23, there were 15,420 remand prisoners, of which 1,101 (7.1 per cent) were for drug offences. There were also 5,640 total sentenced prisoners, of whom 297 (5.3 per cent) were for drug offences. This gives a total custodial population of 21,060, of whom 1,398 (6.6 per cent) were for drug offences (Stats NZ, n.d.a).

This figure was then weighted to account for differences in sentence length between drug offences and all offences, as this will impact the proportion of expenditure related to illegal drugs.

The proportion of drug offences was higher in longer sentencing bands, compared to shorter sentences, suggesting that drug offences receive longer sentences than the average (Stats NZ, n.d.c). To adjust the proportion, the number of days in each length band was calculated (using the mid-point of each period), to derive a percentage of total days (total days for illegal drugs / total days in custodial services). This adjusted the proportion to 7.2 per cent. This results in a final estimated expenditure for corrective services of $120,189,240 in 2022/23.

Community corrections

In New Zealand, the majority of corrective sentences and orders are served in the community. This may include community detention, home detention, and supervision orders. In 2022/23, $287,930,000 was funded for the management and delivery of sentences and orders served in the community, and electronic monitoring of people on bail (Treasury, 2022a). Those who have received a community sentence for illicit drug offences are included.

In 2022/23 there were 30,381 offences, of which 1,638 were illicit drug offences (5.4 per cent of the total) (Stats NZ, n.d.a).

This figure was then weighted to account for differences in sentence length between illicit drug offences and all offences, as this will impact the proportion of expenditure related to illegal drugs; however, this was complicated by the fact that some sentence lengths are unrecorded in the data tool, and this percentage differs between all offences (28.9 per cent) and drug offences (18.3 per cent). However, the differences in sentence length where it was known, were:

- 6 months or less: 26.3 per cent for all offences, 27.1 per cent for drug offences
- over 6 months and up to 1 year: 37.7 per cent for all offences, 46.3 per cent for drug offences
- over 1 year and up to 2 years: 7.1 per cent for all offences, 8.4 per cent for drug offences.

Overall, this suggests that drug offences receive a longer community sentence than the total (Stats NZ, n.d.c).

To adjust the proportion, the number of days in each length band was calculated (using the mid-point of each period), to derive a percentage of total days (total days for illegal drugs / total days in community corrections). This adjusted the proportion to 6.4 per cent. This results in a final estimated expenditure for community corrections of $18,427,520.

Treatment

In this domain, total Government expenditure on health for the 2022/23 financial year is considered, and an estimate made of the percentage of this spent on treatment related to illegal drugs (with the aim that people reduce or eliminate their drug use). This largely involves activities funded by the Ministry of Health and Te Whatu Ora, and all treatment modalities are included.

It is estimated that between 0.52 per cent and 0.63 per cent of the total treatment population seeks treatment for illegal drug reasons. As a proportion of the $21,325,963,000 in the healthcare budget identified as relevant to treatment, 0.57 per cent (the calculated mid-point) is dedicated to illegal drug treatment. Treatment expenditure therefore amounts to $121,557,989 in this model's estimation (Table 3).

Table 3 – Treatment funding

ACTIVITY	FUNDING IN 2022/23
Drug treatment	$121,557,989
Total – treatment domain	**$121,557,989**

Health expenditure

The denominator for this estimate is treatment expenditure. From the Vote Health 2022/23 appropriations, the following are included: $11,707,419,000 to enable the provision of hospital and specialist services, $7,964,207,000 to enable the provision of primary, community, public, and population health services, $1,214,872,000 for Pharmac, $266,465,000 for the Ministry of Health's stewardship role, $163,000,000 for the Māori Health Authority to deliver Hauora Māori services, and $10,000,000 to support 'other' health services. This sums up to $21,325,963,000 (Treasury, 2022e).

Appropriations for Pharmac are included on the premise that there is no systematic method that could be applied to reduce the total health expenditure by a suitable amount to accommodate the difficulty of calculating exact pharmaceutical proportional expenditure on illicit substance treatment (Ritter et al., 2024). Appropriations for stewardship are included on the premise that the Ministry of Health does conduct some illegal drug treatment in this capacity.

Some 'other' health services are excluded as not being relevant to drug treatment: $39 million dedicated to monitoring health and disability consumer interests, and $21 million for problem gambling services. This leaves $10 million unaccounted 'other' expenditure that is included due to an inability to confidently identify what this expenditure entails.

Treatment population

This provides an estimate of the number of people who receive drug treatment across all treatment modalities, as a proportion of those seeking any treatment in the healthcare system.

The Mental Health and Wellbeing Commission reports that in 2022/23, 44,474 people accessed specialist addiction services (which excludes gambling services) (Mental Health and Wellbeing Commission, 2025). This then needs to be adjusted to only account for those seeking treatment for illegal drugs (i.e. excluding alcohol and tobacco).

The 15th *Alcohol and other drug outcome measure (ADOM)* report shows that 62.7 per cent of treatment in the community collections identify alcohol as the substance of main concern for 2022/23, and 1.6 per cent identify tobacco (Te Pou, 2023). It is therefore estimated that 35.7 per cent is related to illicit drugs, while acknowledging the limitation that for some patients, an illegal drug may be a second or third drug of concern. When applied to the 44,474 accessing specialist AOD treatment above, it is estimated that 15,877 people received illegal drug specialist treatment.

It is important to note that people also receive treatment for illegal drug use outside of specialist services, including through General Practitioners (GPs). To account for this, the Australian drug budget relies upon a 'multiplier', based on previous research that estimated met demand for treatment in Australia (Chalmers et al., 2016; Ritter et al., 2024; Ritter & O'Reilly, 2025). Using this method, approximately one-third is added to the total from specialist services. Data could not be located in New Zealand for treatment in other settings, including GPs. Therefore, the same

multiplier as was used in Australia is applied, and this adds 5,398 (rounded to nearest whole) more potential people not already accounted for. To validate this assumption in New Zealand, the number of referrals for specialist AOD treatment (59,580) (*Te Pou*, 2023) was compared to the 44,474 people who received treatment, as it could be assumed that those people then received treatment in another setting (including their GP). The difference between referrals and those treated in specialist services was also one-third, which provides reassurance that this assumption is valid. Then the 25.4 per cent of Opioid Substitution Treatment (OST) patients who received treatment from their GP in a shared care agreement are added in, which adds another 1,332 people (Ministry of Health, 2025).

The final estimate of the number of people receiving treatment for illegal drugs is therefore 22,608.

It was not possible to identify a number for total healthcare treatment in New Zealand (i.e. the number of New Zealanders who sought any healthcare). The NZ Health survey estimates 73.2 per cent of people saw a GP in the 2022/23 financial year (FY) (Ministry of Health, n.d.). Therefore, to be inclusive of all healthcare, the true figure is likely higher than that; however, the NZ Health Survey does not provide an estimate of total access to health professionals. Therefore, tentative bounds of 70–85 per cent were used, and a mid-point estimate of 77.5 per cent, which was applied to the total population of New Zealand at the mid-point of 2022/23 (5,160,600) (Stats NZ, n.d.b). This gives a total treatment population of between 3,612,420 and 4,386,510 people with a mid-point estimate of 3,999,465.

It is therefore estimated that between 0.52 per cent and 0.63 per cent of the total treatment population seeks treatment for illegal drug reasons, and the mid-point of 0.57 per cent is applied to the total treatment health expenditure, for a total of $121,557,989 spent on treatment for illegal drugs.

Prevention

Prevention programmes are those intended to try and prevent drug use from starting, which would then ultimately reduce demand for illegal drugs. Four sub-domains are included within prevention: school-based drug education, general prevention, infancy and parental support programmes, and the Resilience to Organised Crime in Communities programme. Prevention expenditure in 2022/23 totals $26,994,593 (Table 4).

Table 4 – Prevention funding

ACTIVITY	FUNDING IN 2022/23
School-based drug education	$14,918,702
General prevention	$2,379,000
Infancy and parental support programmes	$8,615,238
Resilience to Organised Crime in Communities	$1,081,654
Total – prevention domain	**$26,994,593**

School-based drug education

School-based drug education is delivered to students with the intention of preventing drug use. For this sub-domain, the time spent on illegal drug education in schools, as a proportion of recurrent school expenditure, must be estimated. It is acknowledged that there may be additional programmes that run outside of schools, but these are excluded from this calculation.

This calculation is focused on secondary school (Years 9–13 only). Some health or relationships education in primary or intermediate schools may indirectly prevent drug use, for example, through teaching on dealing with peer pressure. However, there was no evidence located to suggest that education specific to illegal drugs is systematically taught to students in year 8 or lower. This assumption was validated through discussions with teachers and principals.

In New Zealand, illegal drug education can occur (prior to reforms introduced in 2023) in Health or Health and Physical Education. The proportion of time spent specifically on only illegal drugs is difficult to ascertain as to a certain extent this is subject to individual school administration discretion. *The Alcohol and Other Drug Education Programmes: Guide for schools* indicates that the "boards of trustees are required by law to consult their school community at least every two years on how the school plans to implement the health curriculum, of which AoD education is a part" (Ministry of Education, 2014). Therefore, calculating an average proportion requires making some assumptions about hours.

The possible number of school hours is calculated as the average number of weeks of a school year and the average number of hours that students must attend. A standard estimate of 40 weeks of attendance per year was used, with five hours of school attendance per day (with a lunch break not counted). This equates to a theoretical maximum of 1,000 hours of schooling per year.

Calculating an exact proportion of hours spent on illegal drug education is difficult as it is school-dependent. NZ Health Education youth health researcher Dr Jenny Robertson has stated that a Ministry of Education Relationships and Sexual Education report can be used as an approximation of the state of illicit drug education in New Zealand (Tūturu, 2023). In this report, the majority of teachers indicated that Years 9 and 10 received 10–12 hours of relationships and sexuality education (New Zealand Family Planning, 2022). With a lack of better approximations and relying upon the fact that the mean figure (11 hours), is close to the Australian assumption of 10 hours (Ritter et al., 2024), this was used as the average hours per year.

For Years 9 and 10 the health subject is compulsory; therefore, it is estimated that 1.1 per cent of teaching hours (11 from a total of 1,000) is dedicated to illegal drugs.

However, for years 11–13 health is not compulsory and can split into individual subjects such as Health or Physical Education. To adjust for this, the number of students enrolled in either Health, or Health and Physical Education in Year 9 in 2022 was taken (44,464) and then the number of students enrolled in these subjects in Years 11–13 was averaged (4,607) for a proportion of 10.4 per cent (Education Counts, n.d.). It is therefore estimated that in Years 11–13, 0.1 per cent of teaching hours is dedicated to illegal drugs.

Vote Education from Budget 2022 identifies $2,948,369,000 appropriated for secondary school expenditure (Treasury, 2022d). Applying these proportional estimates separately for Years 9–10 and then 11–13, it is estimated that a total of $14,918,702 is spent on school-based drug education.

General prevention

The activities that would be included in this sub-domain are general education (i.e. advertising campaigns, sporting campaigns, and adult or specialty education initiatives). There was no evidence or information located about national-level advertising campaigns or adult/speciality education initiatives in the 2022/23 FY. Vote Sport and Recreation in the 2022 Budget indicates

$4,758,000 expenditure appropriated for Drug Free New Zealand, the prior anti-doping sporting body before the establishment of the Sport Integrity Commission | Te Kahu Raunui (Treasury, 2022i). In the absence of better information, this is the sole programme for this sub-domain. Drug Free New Zealand's activities include medications, 'doping', and recreational drugs, but there was no information to identify the proportions of this focused only on illegal drugs. In the absence of this information, it is assumed that 50 per cent of their activities are related to illegal drugs, for a total of $2,379,000.

Infancy and parental support programmes

This sub-domain requires estimating the proportion of total preventative and intensive family support expenditure dedicated to illegal drugs. Vote Oranga Tamariki in the 2022 Budget appropriates $395,154,000 for prevention and early support programmes and $13,538,000 for intensive support responses (Treasury, 2022g). Prevention and early support are activities to identify and support children, young people, and their families at risk of poor life outcomes. Intensive responses are for children and young people at risk of harm and/or requiring statutory intervention. This is $408,692,000 in total.

This then needs to be adjusted for the proportion related to illegal drugs. For prevention and early support, this was adjusted using the mean figure of the population receiving drug treatment as calculated under the Treatment domain, derived as a proportion of the total treatment-seeking population. Details on how that figure is calculated are found under the Treatment section. This requires an assumption that the treatment-seeking population is reflective of the broader parenting and family population, and is not adjusted for those who have children. However, this allows for a broader definition of 'family' and would include, for example, grandparents caring for infants. The mean proportion is 0.57 per cent, applied to $395,154,000 of prevention and early support funding.

For intensive support, the proportion related to illegal drugs is estimated to be higher. There was no exact estimate able to be found, however, Oranga Tamariki research from 2020 states that indicators of drug and substance abuse are higher for those involved with the care and protection system than for the general population, that parents of children in care have higher rates of methamphetamine-related offences than the national population (7 per cent as compared to 1 per cent), and methamphetamine was mentioned in 29 per cent of Reports of Concern that proceeded entry into care, with substance abuse present in 65 per cent of cases (Oranga Tamariki, 2020). Therefore, without having accurate data for all illegal drugs, the midpoint between 29 per cent and 65 per cent is taken, and thus 47 per cent is used as the proportional estimate for intensive support related to illegal drugs, applied to the total of $13,538,000.

It is therefore estimated that $8,615,238 of infancy and parental support expenditure relates to illegal drug prevention.

Resilience to Organised Crime in Communities programme

Resilience to Organised Crime in Communities (ROCC) is a cross-agency work programme that aims to "combat domestic organised crime by combining social and economic intervention with targeted enforcement action to build local community resilience" (New Zealand Police, 2023). The initiative is intended to socially strengthen communities against domestic organised crime, particularly related to methamphetamine. Therefore, in this report, it is considered as a prevention activity for illegal drugs and is included as a 'bottom-up' expenditure item within this domain.

The budget figures for this programme were obtained via OIA (date 6 June 2025, see Appendix 1) and the actual money spent in 2022/23 is included, not the budgeted amount. This totalled $1,081,654.

It is noted the OIA specifies these costs do not include personnel, only the specific operating costs. To avoid 'double-counting' this initiative, the same amount was then subtracted from the 'routine policing' sub-domain in the Law Enforcement domain.

Harm reduction

Harm reduction programmes are those intended to reduce harm arising from drug use, rather than reducing drug use per se. In New Zealand, in 2022/23, there were two Government-funded harm reduction programmes: the needle exchange programme and drug testing. They received a total of $6,902, 376 in funding (Table 5).

In the Australian drug budget, this policy domain also included supervised injecting rooms, peer-led drug-user organisations, and the take-home naloxone programme (Ritter et al., 2024). New Zealand does not have supervised injecting rooms, or Government funded peer-led drug-user organisations, and naloxone provision was highly limited in scope in this reference year, so was excluded. A future iteration of this report would need to include naloxone provision.

Table 5 – Harm reduction funding

ACTIVITY	FUNDING IN 2022/23
Needle and syringe programme	$5,569,043
Drug testing (checking)	$1,333,333
Total – harm reduction domain	**$6,902,376**

Needle and syringe programme

The New Zealand needle exchange programme in 2022/23 was funded as a central trust, with five regional trusts plus an additional provider through the Aotearoa New Zealand Sex Workers' Collective (NZPC). The programme underwent a review in 2022, which included documentation of the current funding in the report (PWC, 2023). This figure, $5,569,043, was therefore used as the information source.

Drug checking services

In December 2022, the Government announced a $4,000,000 dollar investment in drug-checking services in New Zealand to last over three years (NZ Government, 2022). Information about how that funding would be allocated by year was unable to be sourced. Therefore, assuming equal distribution among the three years, this results in funding of $1,333,333.

How do New Zealanders want the drug budget to be allocated?

To find out how New Zealanders would like public money allocated to reduce drug harm, 1,195 citizens were surveyed in a nationwide representative poll. Of those,1,001 (84 per cent) answered the funding allocation question, which was intended to assess their 'willingness to pay'. The text of the question, including explanation of the drug policy pillars, was:

> *If $100 of the tax you paid each year was being spent by the Government on initiatives related to illegal drugs in New Zealand, how would you like it split up between the following things:*
>
> - *Reducing the supply (e.g. customs and police resources to enforce drug laws)*
> - *Treatment (e.g. providing treatment for people who have problems with drug use)*
> - *Prevention (e.g. providing educational resources to stop people from using drugs in the first place)*
> - *Harm reduction (e.g. providing services like needle exchanges and overdose prevention medicine, so that people who use drugs experience less harm)*
> - *Unsure [Tick box]*

When answering this question, respondents allocated on average $36 to reducing supply, $24 to treatment, $25 to prevention, and $16 to harm reduction (Figure 2). All numbers are reported rounded to zero decimal places.

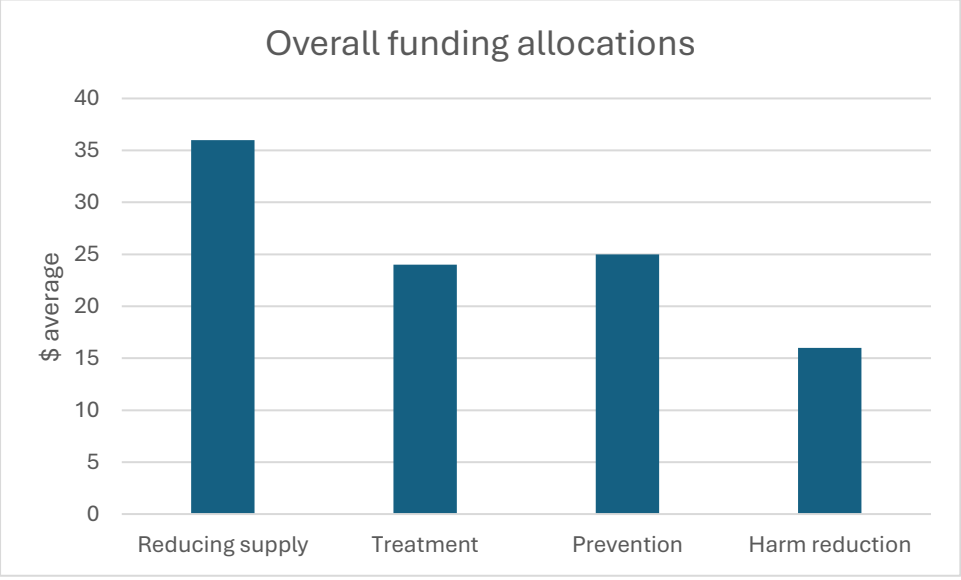

Figure 2 – Overall funding allocations (n = 1,001)

Respondents were asked whether they mostly believe that illegal drug use should be treated as a criminal issue (where users are prosecuted and fined or imprisoned), or a health issue (where most of the effort goes into minimising harm).[2] Of the respondents, 466 (47 per cent) said that a

[2] This was a yes/no choice, where respondents could only select either criminal issue or health issue. They were asked to pick the option closest to their view, even if not exactly right.

criminal issue was closest to their view, and 458 (46 per cent) said that a health issue was closest to their view (8 per cent were unsure).

People's 'willingness to pay' for the different types of policy areas was then re-analysed, based on whether they mostly saw drug use as a criminal or a health issue (Figure 3). Unsurprisingly, those who regarded drug use as more a criminal issue put relatively more funding towards reducing supply, and less towards treatment and harm reduction than those who said a health issue most closely matched their view. Interestingly, however, all respondents allocated a similar proportion of the $100 to prevention.

Those who consider drugs to be primarily a criminal issue still allocate less to reducing supply than what is actually spent now, and more towards harm reduction and prevention than what is spent now. While this group selected that a criminal justice approach was closest to their view, they still allocated over half of their funding to prevention, treatment, and harm reduction, which are considered health-based responses.

It is also noteworthy that while the 'unsure' group was relatively small, their funding allocations more closely resemble that of the group that considered drugs as primarily a criminal issue.

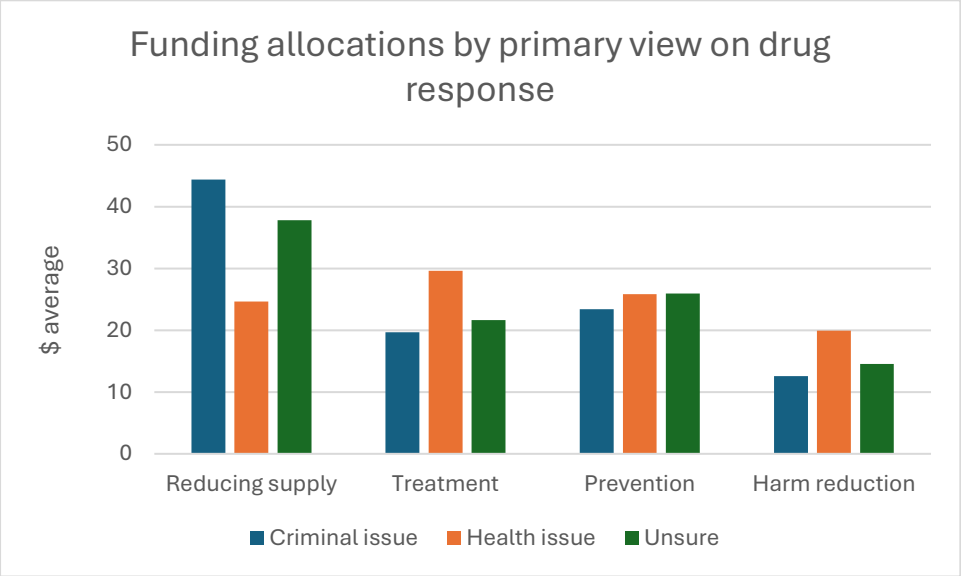

Figure 3 – Funding allocation by primary attitudinal question (n = 1,001)

Respondents were asked which political party they generally supported: 378 (38 per cent) supported a party of the current Government (National, NZ First, or ACT) while 457 (46 per cent) supported a party of the opposition block (Labour, Greens, Te Pati Māori). The remaining 17 per cent were split between 'no party', preferred not to say, or supported a party not currently in parliament (not shown on graph). Those who supported the current Government allocated more funding to reducing supply, and less to treatment and harm reduction than those who supported the opposition block, though respondents were very similar in relation to allocations for prevention (Figure 4). It is also important to note that both groups of respondents allocated less to reducing supply, and more to prevention and harm reduction, than what is actually spent now (as shown by the grey 'actual' bars).

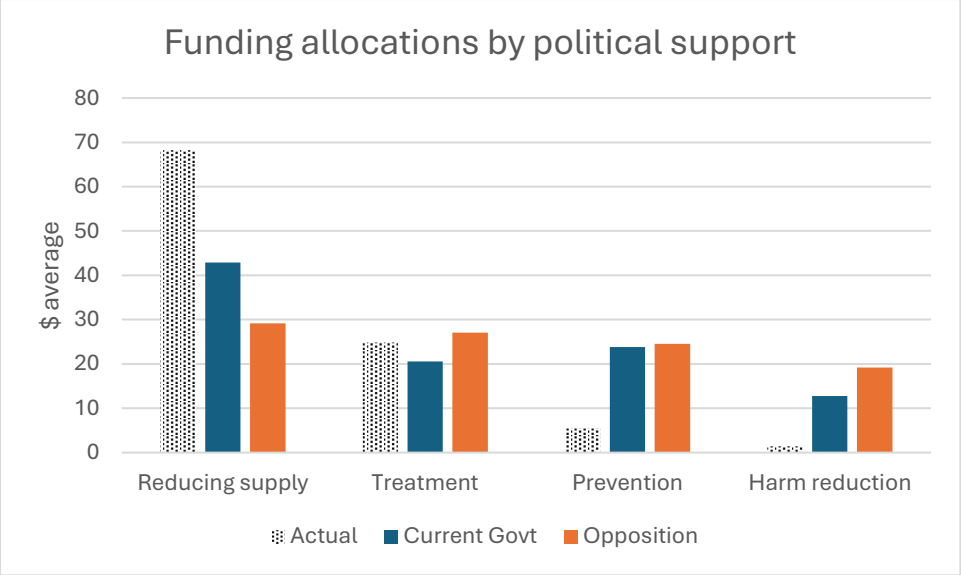

Figure 4 – Funding allocations by political support (n = 833). 'Actual' figures are percentages

There were very minor differences in funding allocation by gender, with males allocating slightly more to reducing supply and slightly less to treatment than females, though these were within the margin of error, and there were minimal differences in allocations for prevention or harm reduction (Figure 5).

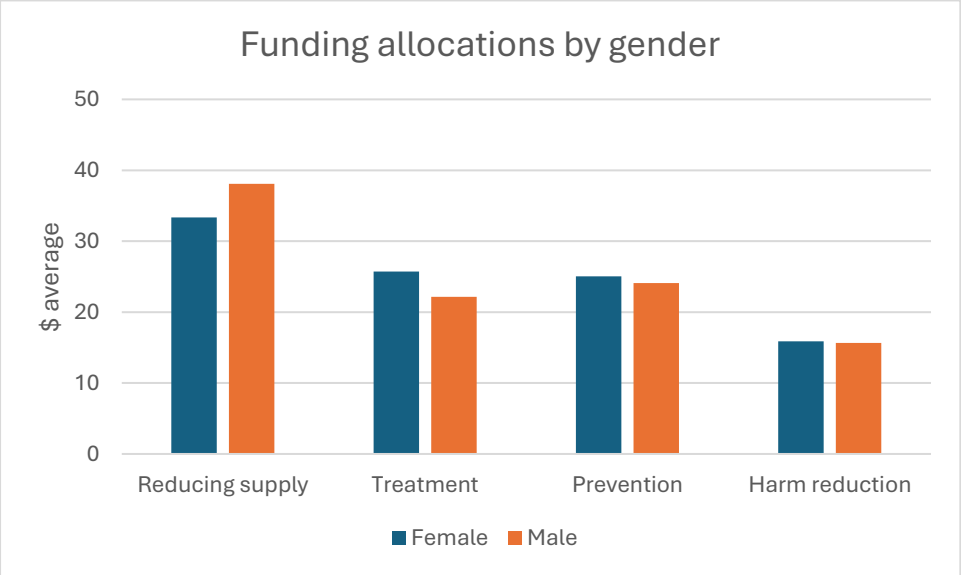

Figure 5 – Funding allocations by gender (n = 999)

Respondents were asked whether or not they had used illegal drugs: 594 (54 per cent) said no, 231 (23 per cent) stated yes, but not in the last year, and 137 (14 per cent) stated yes, in the last year. People who use drugs themselves were slightly more likely to support expenditure on treatment, and less likely to support expenditure on reducing supply. Those who had not used illegal drugs allocated relatively more funding to reducing supply, and less to treatment and harm reduction. Those who had used drugs (but not in the last year) allocated funding midway between those two groups (Figure 6). Interestingly, all three groups were highly similar in their allocations for prevention.

Respondents were also asked whether they had experienced harm from their own drug use, seen someone else (e.g. family member or friend) being harmed by their own drug use, been harmed by someone else's drug use, or could respond that they had not experienced any of these impacts. Of the respondents, 566 (57 per cent) reported no drug harm experience, with the remaining respondents endorsing one or more of the harm types, or were unsure about potential experiences of harm. Funding allocations were similar between the groups; those who had no reported harm allocated slightly more funding to reducing supply, but differences between treatment, prevention, and harm reduction were minor (results not shown in a graph).

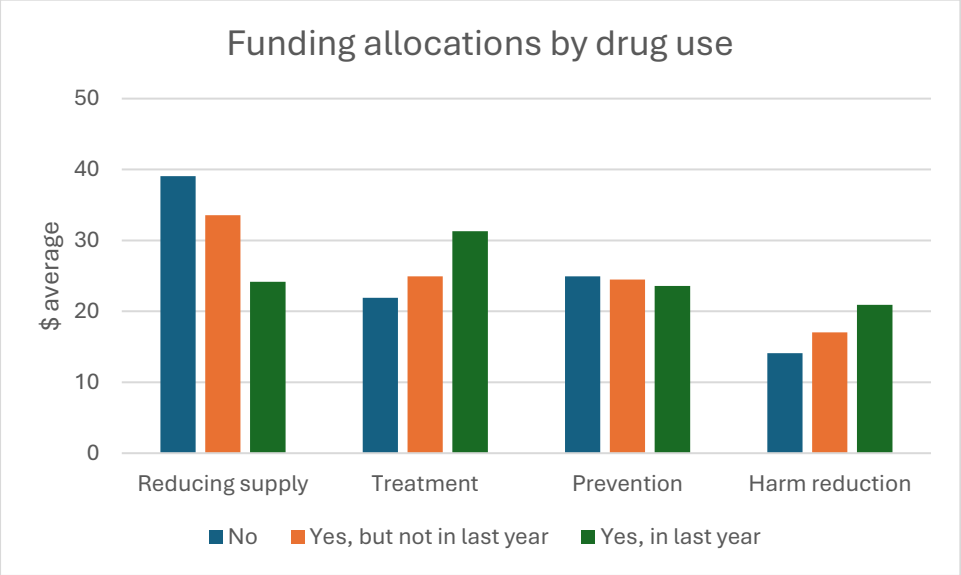

Figure 6 – Funding allocations by drug use (n = 962)

Do New Zealand's drug laws reflect public opinion?

Introduction

Funding allocations for different types of drug policy activities are influenced by policy settings and laws. New Zealand's current drug policy settings have been largely in place for over 50 years. They did not emerge from a vacuum, but were influenced by historical and international events. To understand how New Zealand came to be where we are in our drug policy settings in 2025, it is therefore useful to consider the historical origins of these policies.

The purpose of this section is to explore those origins, paying particular attention to how New Zealand citizens were, or were not, engaged in the decision-making processes. This section asks 1) how did we get here, and 2) have citizen's views and preferences been reflected in drug laws over time?

The 1961 UN Single Convention and New Zealand Narcotics Act 1965

In drug policy, the 1961 United Nations Single Convention on Narcotic Drugs is seen as a significant milestone, which has exerted influence on the global response to drugs since its ratification. The treaty was in part an effort to consolidate existing international treaties into a single document, but it was heavily influenced by countries like the US, who were, at the time, strongly advocating for more stringent responses to drug use and trafficking. The treaty aimed to address 'drug abuse' and to limit drug use to medical and scientific purposes, through taking a 'prohibition'-focused approach to reducing drug supply (including manufacture and trafficking) (United Nations, 1963).

New Zealand had delegates at United Nations Conference on Narcotic Drugs in 1961 and were signatories to the treaty (United Nations, 1961), though New Zealand's motivations for this decision and how it was made are unclear. New Zealand was represented by the Director of the Department of Health's Public Health division, Dr D. P. Kennedy (Unknown reporter, 1961). The Single Convention came into force on 13 December 1964, once it met the requirement of 40 ratifications, of which New Zealand was one (having ratified in 1963). However, as this treaty was not self-executing, all parties had to enact legislation in order to fulfil its obligations. In New Zealand, this was done through the Narcotics Act 1965.

Drafting of the Bill was significantly contributed to by a senior police officer, Detective Chief Inspector Robert (Bob) Walton. In 1963, Walton, at the time a Detective Inspector, was one of the leading Detectives in the Bassett Road 'Machine Gun Murders' (Bainbridge, 2013). The perpetrators of the murders had smoked cannabis (at the time called 'marijuana') prior to the murders and had also consumed alcohol and 'pep pills' (likely containing amphetamine-type stimulants), though it was the presence of cannabis that led to significant concern about the role this had played in the murders. The police were of the view that cannabis contributed to 'homicidal urges'; it is likely this position had been influenced by the 'Reefer Madness' narratives that had come out of the US in previous decades (Boyd, 2010). One of the convicted murderers, John Gillies, later wrote an open letter in 1968 where he attributed his actions solely to "the smoking of marijuana and the consumption of drugs prior to my going to Bassett Road" (Board of Health, 1970).

In 1965, the current Commissioner of Police, C. L. Spencer, attended an Interpol conference, and returned with the view that a global trend towards increasing 'drug abuse' could impact New

Zealand, and that the Police Department needed to be prepared for future developments in this field (Board of Health, 1970). DCI Walton was subsequently sent to the US later in 1965 to learn more about drug law enforcement, and upon his return to New Zealand established the first police Drug Squads (then called Vice Squads) and contributed to drafting the Narcotics Bill (Board of Health, 1970; Yska, 1990).

The Bill was introduced by the Health Minister of the governing National Party, Hon. Don McKay, on 19 August 1965 and in his first reading, he stated:

> The Bill also fully implements this country's obligations under the Single Convention on Narcotic Drugs, to which New Zealand is a party ... By laying down more severe penalties for drug peddling the Bill will help the Police and the Department of Justice to stamp out this type of activity in New Zealand. (NZ House of Representatives, 1965a)

The Bill had its second reading on 8 September that year and was at that time referred to the Statutes Revision Committee (a select committee tasked with regulatory review, particularly in relation to criminal legislation). The Bill was considered 'draconian' for the time in relation to the problem, and in his second reading speech Minister McKay acknowledges this, stating that "Certain other provisions in the Bill go further than the Government would normally consider going", *but this was necessary in order to proactively prepare for the expansion of drug trafficking into New Zealand* and "stamp it out". (NZ House of Representatives, 1965b)

In the second reading, the Hansard records show that the second speaker after Minister McKay was Minister Finlay, the Labour member for Waitakere, who raises some concerns about the infringement of civil liberties and recommends that the Bill be referred to the Statutes Revision Committee. Nevertheless, he appears supportive of the overall premise of the Bill, describing narcotics as:

> the evil that this Bill aims at controlling, and, I should like to think, at conquering, is a revolting and diabolical evil indeed, and I for one am ready to be convinced that the far reaching and draconic powers contained in the Bill are justified.

Similarly, Minister May, the Labour member for Porirua states that "No member on this side of the House [the opposition] suggested that the Bill be held over. In general, we support the Bill." Minister May goes on to raise concerns that drug supply should not be the only focus of the Bill, and that some measures targeting demand should also be considered, including compulsory addiction treatment (NZ House of Representatives, 1965b).

The report from the Statutes Revision Committee was received just two weeks later on 22 September and considered 'under urgency' on 28 September 1965. Two main witnesses addressed the Statutes Revision Committee, one representing the NZ Council for Civil Liberties, and one from the Constitutional Society, both of whom raised concerns that the Bill should not be adopted in its current form, particularly in relation to the search and seizure clause. It appears their opposition to the Bill was focused on the issue of police powers, and the speed at which this Bill (among others) was being progressed, not with the content itself. Indeed, in their November 1965 newsletter, the Constitutional Society state that "While applauding the effort to stamp out the vicious drug traffic, the Society could not but be concerned about the authority given to any member of the Police" (Constitutional Society 1965b). Their AGM agenda from the same year states that "the society commends the end, but not the means" (Constitutional Society, 1965a).

The Labour party members shared some of these concerns about police powers, and were voiced in Parliament, but the opposition did not feel it necessary to vote against the Bill, which subsequently went through its third reading and passed into law on 5 October 1965 (NZ House of Representatives, 1965c). These doubts were reported in the media, for example, page 1 of *The Press* on 6 October 1965 reported the Labour party members' concerns, and that those had not been sufficient to vote against the Bill, but did not contain any editorial comment beyond reporting of the debate in Parliament and the fact that the Bill had passed (Unknown reporter, 1965). The fundamental premise of the Bill, or the need for it, appears to have had no meaningful discussion, challenge, or public consultation.

Upon the passing of the Narcotics Act 1965, New Zealand had a piece of legislation that criminalised both drug trafficking and possession and granted police significant powers of enforcement. This had occurred in order for New Zealand to be compliant with the UN Single Convention, despite there being very little drug use or harm evident in New Zealand at the time. There had been little public engagement with, or consultation on, these drug policy settings that would shape the next 60 years; therefore, whether this legislation reflected the will of the New Zealand people at the time is unclear.

The Blake-Palmer reports, UN Convention Amendments 1972, and the Misuse of Drugs Act 1975

In April 1968, the Health Minister, Hon. Don McKay requested that the Board of Health undertake an enquiry into 'drug dependency and drug abuse in New Zealand', which was to be chaired by the Deputy Director-General of Health Dr Geoffrey Blake-Palmer, in response to rapidly rising rates of drug convictions and number of people requiring treatment for drug issues in the late 1960s. It is interesting to note that numbers of convictions had risen since the passing of the Narcotics Act, but the committee in its first report did not appear to query what the role of the legislation itself was in this trend. The subsequent reports are known as the Blake-Palmer reports.

The first report was published in February 1970 and served as a baseline from which the problem of drugs could be assessed in New Zealand (Board of Health, 1970). To support the work of the committee, the members received reports from police officers and medical staff, and heard from witnesses, including 23 people who had lived experience of drug use. They also undertook 40 qualitative interviews with people "involved in drug abuse" (Board of Health, 1970, p. 23). The reports of the interviews show a remarkably nuanced view of the problem, with exploration of benefits and risks of drug use, as well as risk and protective factors. This led the committee to conclude that "Any attack on the problem must be on all fronts. Limiting availability, the most obvious course, can never be complete or final. Once one drug or source of supply is brought under control, the pressure builds up on another" (Board of Health, 1970, p. 38). This needs to be understood in the context of there being little evidence at the time of trafficking, and what little existed was "mostly unorganised and on an individual basis" (Board of Health, 1970, p. 31).

The report places an emphasis on the need for treatment, and that the police should "continue to exercise discretion" so treatment can be sought without "fear of unnecessary repercussions" (Board of Health, 1970, p. 50). The committee then goes on to place an emphasis on the need for effective prevention. They conclude that drugs were not a major social problem in New Zealand at the time, and that the focus must be on more than control and treatment, with greater attention put to psychological and social factors that influence use. They recommended against any relaxation of the penal provisions, particularly because of the discretion that was being utilised,

and that prevention efforts needed to be centred around both education and consideration of social context.

In April 1970, shortly after the publication of the first report, it was deemed that due to the rapidly changing nature of drug issues in New Zealand, and globally, it was necessary for the review to continue. The second report was published in 1973 (Board of Health, 1973). The committee undertook a review of the existing legislation, while also considering the treatment needs of people who use drugs and the health education needs of the wider community. The report underwent community consultation, with experts, and with other organisations, including universities and the student body (through the New Zealand University Students Association and individual student associations), with 70 New Zealand witnesses presenting to the committee.

Submitters raised concerns about the severity of criminal penalties and whether or not courts were sufficiently focused on medical treatment and rehabilitation, which led the committee to put greater focus on reviewing the existing legislation. The committee formed the conclusion that the potential for harm was great enough to warrant the retention of legal penalties, but the New Zealand legislation was due for "consolidation and revision" (Board of Health, 1973, p. 48). However, there needed to be a way of differentiating the response to drugs on the basis of their relative potential for harm, and there needed to be continuing work on the development of alternatives to legal sanctions, which "should be used as sparingly as possible, when other measures have been tried and failed" (Board of Health, 1973, p. 49). The committee highlights that an "effective programme must cover control, treatment, professional and public education, research and the alleviation, as far as possible, of the conditions which lead some people to use drugs unwisely" (Board of Health, 1973, p. 96), but concludes that while control measures are well-established, and treatment has been extended, little progress has been made in regard to prevention.

While the committee was conducting its review, there was a revision to the UN Single Convention on Narcotic Drugs in March 1972 (New Zealand signed 15 December 1972), which necessitated that New Zealand also review and update its legislation to be compliant with the new obligations (United Nations, 1972). Adviser to the committee J. I. Ashforth (Advisory Officer Toxicology from the Department of Health) attended the 1972 UN Convention to review the Single Convention on Narcotic Drugs (Board of Health, 1973).

There were a number of amendments made to the UN Single Convention, though notable to New Zealand's circumstances where that the amendments instructed that:

> The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends. (United Nations, 1972, p. 19)

Thus, the amendments could be seen as putting greater emphasis on treatment and rehabilitation. However, it is important to note that the explanatory communication includes control measures and penal sanctions as examples of prevention (though not exclusively). The explanatory commentary notes that:

> 10. The administrative control measures and penal sanctions for which the Single Convention provides are intended to prevent the abuse of narcotic drugs and therefore constitute measures of "prevention". When using the very broad term "prevention" in

> paragraph 1, the authors of that provision however thought of other additional measures suitable to keep people from abusing narcotic drugs. "Prevention" as used in this place would include all practicable economic and social measures capable of changing a social atmosphere or subcultural conditions responsible for the development of personality traits finding expression in the abuse of narcotic drugs. Early identification of groups prone to abuse narcotic drugs and education may also be measures of prevention. (United Nations, 1976, p. 86)

The Protocol adds a provision to Article 36 allowing for "treatment, education, after-care, rehabilitation and social reintegration" (United Nations, 1976, p. 76) as an alternative to, or in addition to, conviction or punishment. Though this is further clarified in the explanatory commentary that it is expected this will occur only for relatively minor offences.

Against this backdrop of the Blake-Palmer reports and the amended UN Single Convention, it may have been expected that the subsequent New Zealand legislation would put greater emphasis on treatment and prevention, and alternatives to conviction or punishment. Certainly, this had been the tone of the Blake-Palmer reports, which had included community and expert consultation and had intentionally sought to include the perspectives of people who use drugs. This, however, turned out not to be the case.

The Drugs: Prevention of Misuse Bill (which would later become the Misuse of Drugs Act) was introduced during the term of the third Labour government of New Zealand, by the Health Minister, Hon. Bob Tizard, and had its first reading on 28 March 1974. In his first reading, Hon. Tizard stated that the Bill had given consideration to the Blake-Palmer reports, and was a full implementation of New Zealand's commitments to the amended UN Single Convention. The New Zealand legislation was therefore drafted with the (already signed) UN Single Convention front of mind and, therefore, challenging the underpinning policy settings of the UN Single Convention would have been difficult, even if the New Zealand Government had wanted to. The Bill established different classes of drugs to reflect harmfulness, which had been recommended in the Blake-Palmer reports. Support from the opposition National party for this Bill was clear from the outset, with the Opposition Leader, Hon. J. R. Marshall stating that "I assure the Minister that the National Party will support legislation intended to prevent the misuse of drugs" (NZ House of Representatives, 1974). The Bill was then referred to the Statutes Revision Committee.

The Bill had a significantly longer period with the Statutes Revision Committee than its predecessor (the Narcotics Act), with the second reading not until 22 July 1975 (NZ House of Representatives, 1975). Opposition to the Bill was also more sustained than for the Narcotics Act, with significant critique of the Bill from the public and interest groups, particularly in relation to cannabis (then more commonly called 'marijuana'), and particularly from students. Despite this, there was very little opposition to the Bill from within Parliament and it was supported by both Government and the Opposition. The then Health Minister Hon. T. M. McGuigan stated in his second reading speech that there was a need for education and treatment, but also that

> the Bill clearly shows the determination of the Government and Parliament to deal effectively with a very widespread social problem by striking at the means by which illicit drugs become available to the community. There can be no relaxation at all in the drive against illicit trafficking in drugs. (NZ House of Representatives, 1975)

The Bill had its third reading and passed on 8 October 1975 (not long before the elections that year, which the Labour Government lost). Despite the opposition to the Bill and the concerns from the review committee that had led them to highlight the need for increased treatment, prevention, and rehabilitation, the legislation did not enact a balanced response across the drug policy pillars, and maintained the prohibition-based settings of both the UN Single Convention and a continuance of the approach from the Narcotics Act. The calls from the Blake-Palmer reports to strengthen prevention, education, and treatment went largely unheeded (or were ignored), and the opportunity to enact the intent of these reports and their recommendations in the legislation was missed.

Reviews and amendments to the Misuse of Drugs Act

Since the Misuse of Drugs Act was passed there were some minor amendments made, but the first significant review of its effectiveness was initiated in 2007. These reviews are discussed because they involved significant community consultation, and therefore, reflected the views of New Zealand citizens at those times. The aim of this section is to discuss what has happened when the laws have been reviewed and citizens have had the opportunity to formally comment on them.

The 2011 Law Commission Review

In 2007, the Government (the fifth Labour Government of New Zealand) requested that the Law Commission undertake a comprehensive review of New Zealand's drug laws (New Zealand Law Commission, 2010). The rationale for requesting this review was that significant changes to the drug landscape had occurred since the passing of the Misuse of Drugs Act 1975, and there were concerns about inconsistencies between the Misuse of Drugs Act and the goals of the National Drug Strategy. The review continued through the 2008 change in Government, and the Law Commission produced a comprehensive issues paper, upon which it invited public submissions until 30 April 2010, to supplement targeted consultation meetings (New Zealand Law Commission, 2010). Over 3,800 submissions were received and considered, with the Law Commission highlighting the diversity of views that were held by the public in the final report (New Zealand Law Commission, 2011).

The Law Commission report was released in 2011 and made a number of major recommendations, including that "the Misuse of Drugs Act 1975 should be repealed and replaced by a new Act, which should be administered by the Ministry of Health" (Recommendation 1), and "there should be a new regime with its own criteria and approval process for regulating new psychoactive substances" (Recommendation 2).[3]

The report presented a strong case for change, concluding that the Misuse of Drugs Act placed an unbalanced emphasis on supply reduction, which was inconsistent with the National Drug Strategy, and was resource intensive, while neglecting other key policy areas such as demand reduction and problem limitation. The report also emphasised the adverse social consequences that arose from a punitive approach (New Zealand Law Commission, 2011).

[3] This recommendation resulted in the Psychoactive Substances Act 2013. This Act has been excluded from the scope of this report, as while it remains New Zealand legislation, no products have been or are licensed for sale. The Psychoactive Substances Act did not alter the approach to drugs as outlined in the Misuse of Drugs Act 1975.

Importantly, the Law Commission acknowledged that some recommendations were not able to be made, because of New Zealand being a signatory to the UN Conventions. Therefore, the decisions made at the UN Conventions in 1961 and 1972 were a restriction on the ability of the Law Commission to fully consider the public's views on drug policy, though whether or not New Zealand should be a signatory to this had not been tested at the time against the will of the people.

Noting that there was an election to be held later in 2011, the Associate Health Minister Peter Dunne acknowledged the review findings and concurred that "it is clear to the Government that the Misuse of Drugs Act needs updating" (Dunne, 2011) and that this work would be completed by the next Government. Though the National-led Government was returned following the 2011 election, the review of the Misuse of Drugs Act did not occur. The Law Commission website tracks implementation of their recommendations, and still notes that only two of the 144 recommendations were implemented from this review, and this does not include Recommendation 1 (New Zealand Law Commission, n.d.). In 2017, when campaigning in the lead up to the 2017 election, Labour stated they would take a health-based response to drugs and referenced the Law Commission review when discussing their policies (New Zealand Drug Foundation, 2017). While some amendments to the Misuse of Drugs Act were made (as later discussed), the fundamental premise of the Act remained unchanged, and the primary recommendation of the Law Commission review was not adopted by the Government.

The 2018 Mental Health and Addiction Enquiry and the 2019 Discretion Amendment

In 2018, the Government announced a significant review of New Zealand's approach to mental health and addiction, and the services it provided for those, including prevention. The review included substantial public consultation, with over 2,000 people attending public meetings and over 5,000 written submissions. The report highlights the "striking degree of consensus, from most parts of New Zealand society, about the need for change and a new direction" (Government Inquiry into Mental Health and Addiction, 2018). The report strongly endorses the view of the prior Law Commission review about the need to replace the Misuse of Drugs Act, and further emphasised the need for a health-based approach to drugs, which would require an injection of investment. The recommendations of this review, in relation to New Zealand's response to illegal drugs, were not implemented by the Government.

It is, however, important to note that in 2019, the Misuse of Drugs Act 1975 underwent an important amendment introduced by the sixth Labour Government of New Zealand (Labour in coalition with NZ First, and with a confidence and supply agreement with the Green Party). The Misuse of Drugs Amendment Bill 2019 solidified into law the Police's existing discretion to only prosecute for possession or use of drugs if they consider it to be 'required in the public interest'. Under the new law, Police must consider whether a health-centred or therapeutic approach would be more beneficial to the public interest than a prosecution (New Zealand Parliament, 2019b).

It was hoped that this amendment would be a positive step towards a health-based approach to drugs and would result in a reduced number of drug possession convictions. The interim review in 2021 found that possession convictions continued to decline, continuing a longer-term trend, though concerns remained about inequities of outcomes and the capacity of health services to provide services upon referral (Ministry of Health, 2021). A full review was scheduled to be completed in 2024, but progress on this is currently unknown.

The 2020 cannabis legalisation referendum

It is important to include a discussion of the 2020 cannabis legalisation referendum, because it is one example where New Zealand citizens had their opportunity to vote on a drug policy issue, though it is important to note that this was not a deliberative process, and did not test preferences overall for changing drug law or priorities for funding.

Though there had been discussions publicly and in various community groups about decriminalising or legalising cannabis in New Zealand, this had never been seriously contemplated by either of the major political parties. The Green Party had been calling for reform for a long time, citing the need for drug policy to be evidence-based and asserting that prohibition of drugs can cause more harm than it prevents in a 2016 position statement (Green Party New Zealand, 2016). At the 2017 election, a government was formed between Labour and NZ First (in coalition) and confidence and supply support from the Greens. As part of their confidence and supply agreement with Labour, a commitment was made to hold a referendum on cannabis legalisation after the 2017 election.

In May 2019, a background cabinet paper outlining the options that had been considered for the referendum and the draft legislation was released as the Cannabis Legalisation and Control Bill (New Zealand Parliament, 2019a). This was voted on in a referendum at the 2020 election, with the question posed: Do you support the proposed Cannabis Legalisation and Control Bill? The referendum failed to pass, with 51.1 per cent of votes 'no' and 48.8 per cent 'yes'.

Academic analyses have considered reasons for why this referendum failed to pass (Fischer & Hall, 2021; Rychert & Wilkins, 2021), but it is important to highlight those that related to public involvement. The Bill itself had been developed through international consultation and considering best-practice in public health and drug policy. However, there had been little public involvement or consultation on the contents of the Bill, and it had not been developed using deliberative democratic processes. The Ministry of Justice explored the potential of deliberative democracy for the cannabis referendum, including citizens' assemblies, juries, and forums. The proposal was ultimately for a citizens' jury, which would be used to build public engagement in the referendum and policy issue. However, the decision was made not to proceed with this, though the rationale for not doing so is unclear from the documents released (Ministry of Justice, 2018).

Therefore, citizens were being asked to vote on something they had little input to and had not had opportunities to deliberate on the contents. It had been considered that post-referendum, assuming it passed, detailed consultation and changes to the Bill could be made at the select committee stage, but the process never made it that far.

Though the referendum was only related to cannabis, and was specifically related to the proposed Bill, rather than more widely on drug policy settings, this is included because it is an example of direct democracy occurring in relation to drugs in New Zealand. It is important to note though that there were no other options provided in the referendum – i.e. a citizen could not vote 'no' to cannabis legalisation but 'yes' to decriminalisation, or to any other modification to drug policy settings, or express their preferences on funding and resource allocation.

Summary

New Zealand's drug policy settings have remained fundamentally unchanged since the 1960s, and were driven by the UN Single Convention of 1961. There appears to have been very limited

public engagement on this at the time, which makes it difficult to conclude it represented the 'will of the people'. Even if it had, there have been fundamental changes in both the drug market and our understanding of drugs and drug harm since that time, which would mean further consultation with New Zealanders is warranted.

Therefore, how can our elected representatives be confident the policy settings we have had in place since the 1960s reflect the views and priorities of New Zealanders in 2025?

When public engagement has occurred, for example, through reviews and inquiries, there have been strong signals for change, which have not been implemented. New Zealanders consistently say they want something different during opportunities for consultation, but changes are not made.

The funding across the four drug policy pillars is strongly influenced by the underpinning policy settings, and the way in which funding has been allocated has not been tested against public preferences by the Government. It is important to note though that in polling commissioned by the New Zealand Drug Foundation in 2022, there was "strong support for more funding to be provided for treatment and education (82%) and harm reduction initiatives like drug checking (74%)" (New Zealand Drug Foundation, 2022).

The question posed in this section is when, if at all, since the New Zealand 1961 Narcotics Act, has our overarching response to drugs, and the drug policy settings and associated funding allocations, been tested against the views and priorities of the New Zealand people? It is acknowledged that the cannabis referendum gave New Zealand citizens the opportunity to vote on one legislative option (legal regulation) for one drug (cannabis), but that this did not represent a thorough test of New Zealanders' views overall on drug policy settings. The conclusion reached is that policy settings and associated funding allocations have not been meaningfully tested against New Zealanders' preferences, or when they are, these changes are not implemented.

Achieving drug policies appropriate for the 21st century

Different democratic processes

Given that New Zealand's drug policy settings and associated funding allocations are not based on evidence of what works and do not reflect community views, it is important to then consider alternatives. There is value in exploring deliberative democratic processes, which are useful for helping to resolve complex or politically challenging policy issues, such as drug policy.

New Zealand is a representative democracy, where citizens elect a Parliament, which legislates on their behalf. The Government is responsible for collecting revenue through taxation, which is then allocated through budget processes. In a representative democracy, citizens have a broad expectation that parliamentarians are responsive to their views.

Those elected may become disconnected from the needs and views of those who elected them, or be subject to political pressures that are disconnected from evidence and/or citizens' views. This is a particular issue for drug policy, where the risk of taking a health-based or harm reduction approach may be perceived politically as being 'soft on crime'. Therefore, there are political risks in this policy space, and politicians may not feel they can make evidence-based decisions.

Globally, there are concerns about declining trust in democratic political systems, described as a 'democracy crisis'. Recent research found that "trust in representative institutions[4] has been declining across the democratic world in recent decades, while trust in non-representative 'implementing' institutions[5] has been stable or rising" (Valgarðsson et al., 2025). This is consistent with recent findings from the New Zealand General Social Survey, which found that trust in parliament decreased the most in 2023 compared with other institutions, down to 4.9 from 5.7 in 2021 (where 0 is no trust and 10 is complete trust). In contrast, trust in the police was rated at 7.4 out of 10 in 2023 (Stats NZ, 2024).

With global research highlighting the particular lack of trust globally in elected representatives, the authors conclude that:

> If it is something about the way democratic politics is practised that citizens distrust, perhaps those politics need to change. Given citizens' continually high support for democratic ideals, those changes may well be in the direction of more democratic governance rather than less. (Valgarðsson et al., 2025)

Rather than allowing democracy to erode and autocracy to build, there are increasing calls for democratic systems and practices to be reformed and strengthened.

Representative democracy can be contrasted against direct democracy, whereby citizens directly vote on policy measures or issues, without intermediaries. Direct democracy can be viewed as overcoming some of the limitations of representative democracy, particularly the lack of responsiveness to citizens. One of the mechanisms for direct democracy is citizen-initiated referenda, which are possible in New Zealand should at least 10 per cent of eligible voters sign a petition supporting the proposed question, though it is important to note the referendum results are non-binding.

[4] The authors define these as parliaments, Governments, and political parties.
[5] The authors provide examples of these as the civil service, legal system, and police.

Participatory democracy and deliberative democracy are two concepts that combine elements of both direct and representative democracy. Participatory democracy creates mechanisms for citizens to be directly and actively engaged in policy processes (both agenda-setting and policy making), which are greater than just voting (Duea et al., 2022; Pateman, 2012). Deliberative democracy is a related concept, in which participation of citizens is prioritised, but adds the requirement of deliberation (Abelson et al., 2003; Degeling et al., 2017). Deliberative democracy maintains that no policy can be made without authentic deliberation, where decision makers are given time and information that enables them to focus on an issue. It is seen as more than just an aggregation of individual preferences and requires that decision making be collective, with a view towards consensus building (Elster, 1998). Deliberative democratic processes aim to draw people together through discussion, learning, and the respectful exchange of views. In doing so, outcomes are not only likely to better represent the views of the people, but also strengthen community and civil bonds, and engage citizens more meaningfully in issues of importance.

Deliberative democracy in practice can include mechanisms such as citizens' assemblies, deliberative polling, and participatory budgeting. In a citizens' assembly, a representative sample of the population meet to engage in policy-making processes, aided by experts. The method is considered particularly useful for complex problems, or those that are strongly influenced by values (Ferejohn, 2008; Walker et al., 2020). Examples include the recent Irish Citizens' Assembly on Drug Use, which was asked to consider the "legislative, policy and operational changes Ireland could make to significantly reduce the harmful impacts of illicit drugs on individuals, families, communities and wider Irish society" (Houses of the Oireachtas, 2024). The assembly met six times in 2023, and published its report in 2024, with 36 recommendations that are currently being considered by the Government. The overarching recommendation was that the State should pivot to "a comprehensive health-led response to drug use" (Houses of the Oireachtas, 2024) and then makes specific recommendations for legislation, strategy, policy, and practice.

Deliberative opinion polling is a method trademarked by James Fishkin (Fishkin et al., 2000), in which a representative sample is polled on an issue, then has the opportunity for deliberation and learning, after which they are polled again. This final result is considered to be reflective of the opinion the public would take, if they had the opportunity for deliberation (Fishkin et al., 2000).

Participatory budgeting is a slightly different, but related, deliberative technique, in that the output is directly related to allocation of funding, rather than views on an issue (which may then influence funding decisions). Participatory budgeting can occur at different scales, and take different forms, with examples worldwide (Williams et al., 2019). When designed well, participatory budgeting has been found to be effective, and to have additional benefits of increased citizen engagement and greater confidence in democratic processes (Williams et al., 2019).

Findings from the participatory workshops

Overview

Given the potential for participatory democracy processes to be a useful technique for improving drug policy, it was valuable to explore this further with a small group of New Zealand citizens. These findings could then be used to inform a larger-scale process, such as a citizens' assembly, similar to what has happened in Ireland. The aim of undertaking this part of the project was to find out whether people's individual views changed through learning more about drugs and drug

policy, if a group could reach consensus on preferred funding allocations, and how valuable or useful they found the deliberative group learning process.

To do this, a group of 10 participants was established, all of whom were retired and living in Christchurch. The group met seven times in 2025 to learn about and discuss drug policy. Priorities and discussion topics were agreed by the group, with information (including guest speakers) arranged by Dr Crossin. Workshop topics were thematically organised around the drug policy pillars. A full list of topics and speakers is provided in Appendix 2.

Group consensus

The statement below represents the output of the group that went through the deliberative learning process. This was agreed by all members of the group, and is included here without amendment.

The group decision was to agree on a set of principles and recommendations as a consensus statement, rather than reach an agreed position on the allocation of funding. The logic for this was that the group felt that though they had learned a lot over this process, there was still more to learn, and the group did not feel confident in agreeing on preferred funding allocations. The second, and more important, reason was that the group was of the view that if you get the principles right, then the funding will follow.

The group also emphasised the seriousness of drug harm and drug policy to New Zealand, and the complexity of the issues, and therefore recognises that the stakes in making good decisions are high.

The following represents the group consensus:

1. *All four drug policy pillars are important, they should all be funded appropriately.*
2. *The priority for allocation of resources should be based on evidence, and consider the relative harmfulness of drugs, with more harmful drugs receiving proportionally high funding, with an overall move towards a health-based approach to drug use.*
3. *Drug policy decisions should be made through processes with greater democratic involvement, and include deliberation and learning, in order to improve evidence-based decision making. This could include a series of Citizens' Juries or a larger Citizens' Assembly. The group specifically recommends that:*
    - *decisions about drug policy should not be solely made by the Government*
    - *decisions need to be maintained more consistently, with less political influence.*
4. *Greater emphasis must be put on education and prevention across the life-course, but with a particular focus on early life and young people. The group specifically recommends that:*
    - *education should not just be within schools; additionally medical, harm reduction, and law enforcement services should also be funded to provide appropriate education*
    - *programmes that improve early childhood, and reduce trauma and adverse experiences, should be strongly prioritised for prevention funding*
    - *the Government should fund appropriate education and health promotion campaigns that could be used for the general population and for young people.*
5. *Police and law enforcement resources should be re-prioritised towards reducing drug importation and responding to the black market, and away from individual-level use. The group specifically recommends that this should not represent a cost-saving, but is a*

reprioritisation, not a removal of funding. The funding needed for harm reduction, treatment, and prevention should be new funding, and not from any reduction in Police funding.

6. *Greater investment in drug treatment is needed, including treatment in corrective services. This needs to be supported by programmes that create an environment of help-seeking and reduce stigma. The group recognised the value of lived experience in supporting others experiencing harm.*
7. *Greater investment in harm reduction is needed, because it is a pragmatic and practical response to drugs, and harm reduction principles and programmes need to be publicised, to increase public knowledge of these.*
8. *Any changes to drug policy must be developed with strong and appropriate engagement with communities most impacted by drug harm, including Māori and Pasifika communities. The group specifically recommends that:*
    - *more funding for interventions focused on reducing inequities in drug use and harm is needed, and these must be in areas of social deprivation where need is greater.*
9. *Current decisions, including funding allocations, are influenced by the current laws. The group specifically recommends that alternative drug law options must be thoroughly investigated as a priority, including both decriminalisation and legal regulation models (for drugs with lower harm). This should consider the experiences of other countries, be evidence-based, have strong democratic involvement, and with a commitment to action from the Government.*
10. *Any change to drug laws, particularly consideration of legal regulation, should address the influence of industry, and the potential for lobbying.*

Individual survey results

Prior to the group deliberative learning process beginning, 70 per cent of participants stated that drugs are a health issue as their primary view, with 30 per cent unsure. No participants selected 'criminal issue' as their primary view. After the group-learning process, 90 per cent of participants stated that drugs are a health issue, with 10 per cent unsure.

All participants changed their funding allocations following the group learning process, with shifts in single domains ranging from 4 per cent to 100 per cent. However, there was no consistent trend in the direction of changes, either away from or towards a particular policy domain.

One notable pattern that emerged from the final survey was that individuals tended to spread their funding allocations more evenly across the four drug policy pillars, after they had learnt more. In the first survey a number of participants allocated 100 per cent of their funding to a single policy domain, whereas this did not occur in the second survey. This suggests that participants concluded that all drug policy domains are important, rather than allocating their funding only in one or two areas.

The learning process

A debrief was conducted with the group after the deliberative group workshops, with the aim of understanding the participants' experience of the process, and to inform future deliberative democratic processes.

All participants emphasised the value of the group deliberative learning process, and felt that it was informative and helpful. They highlighted the complexity of drugs and drug policy, and

expressed that they were now strongly aware this was an issue that required nuanced and thoughtful responses. They expressed that 'quick fixes' were not an option, but that they felt like positive change was possible. One participant stated that:

> It [the group learning process] reinforced the thinking in me that there is a solution, and we're going to be able to get there.

While some participants felt their views had changed significantly through the process, others thought their views had only changed a little, but importantly, they now felt more secure in their perspectives. This is reflected in the individual survey responses.

Most participants did not think there was a 'single moment' that changed their views, but rather it was the accumulation of knowledge and the diverse perspectives that had resulted in their views changing. Some participants emphasised hearing from someone with lived experience as particularly impactful, whereas others felt it was learning from people who were known to have high standing in their fields that was impactful for them. This highlights that a diverse range of perspectives, including expertise arising from both lived experience and professional standing, are valuable to a group deliberative learning process, as illustrated by this participant:

> The great benefit of a group like this is hearing different responses; it's just so beneficial.

Participants strongly endorsed both the 'group' and 'deliberative' components of the process. They learnt as much, if not more, from the discussion with the group, than what was learnt from hearing directly from those with expertise. The value of the group was in diverse perspectives and lived experiences, and by questioning and sometimes challenging the views of others, it helped improve their understanding. One participant explained this as:

> If you don't discuss it, how do you get information, how do you swap ideas? People have very set ideas and this is a good example of it. I think we all had very set ideas on drugs, given our age group … but without the discussion and other people's ideas, we couldn't have changed our ideas.

Participants also felt that by having a group process, it helped build consensus over time. Discussion and compromises were held on the final consensus statement, which could happen constructively given everyone had been going through the group learning process together. There was a lot of buy-in from the group and a shared desire to produce something of value, which meant everyone worked towards their common goal. This was satisfying for the group and for individuals within it, as illustrated by this participant:

> Being in a group like this, hearing both experts and other people's views, you can't walk out the door being the same as when we walked in.

Based on their experiences, the group strongly endorsed the idea of a Citizens' Assembly on Drugs as a useful and powerful process, which could lead to positive outcomes, and had this as a recommendation in their own consensus statement (provided above).

Recommendations and conclusions

The following recommendations were developed after completing all three phases of this project, and reflect the overarching conclusion that there is a significant mismatch between the current funding allocations across drug policy areas and New Zealanders' preferences. New Zealand citizens want proportionally less spent on law enforcement and more spent on treatment, prevention, and harm reduction.

These funding allocations, where most money goes to law enforcement, are a consequence of New Zealand's fundamentally prohibition-based drug policy settings. This is reflective of a longstanding disconnect with the will of the people in New Zealand's drug policy settings, which is evident from the 1960s onwards.

Recommendation 1: Immediately increase the funding for prevention, treatment, and harm reduction in New Zealand, to match stated community preferences.

Rationale for Recommendation 1

Most of the money that goes into proactive responses to illegal drugs in New Zealand is spent on law enforcement and supply reduction efforts. This is significantly out of step with community preferences on funding allocations.

While survey respondents' views differed on whether drugs should be primarily treated as a criminal justice or a health issue, even those who viewed drugs as primarily a criminal issue still allocated proportionally less resources to law enforcement and proportionally more resources to prevention and harm reduction than what is actually spent now.

While the New Zealand proportional spending between the drug policy pillars is similar to that of Australia (Ritter et al., 2024), the spending per person and as a proportion of government expenditure is less than half that of Australia. Australia spends 0.6 per cent of government expenditure responding proactively to illegal drugs, equivalent to $210 per person. New Zealand spends 0.3 per cent of government expenditure, equivalent to $95 per person.

The increase in funding that would be required in treatment, prevention, and harm reduction is calculated below, in order to both increase the total investment in responding to drugs, but, importantly, to also allocate this in a way that is in line with community preferences (Table 6). This would create balance among the drug policy areas, while still maintaining funding for law enforcement.

Table 6 – Funding allocation to meet community preferences

POLICY DOMAIN	FUNDING IN 2022/23	ACTUAL PERCENTAGE	FUNDING TO REACH PREFERRED PERCENTAGE	PREFERRED PERCENTAGE
Law enforcement	$334,013,805	68.2%	$334,013,805	36%
Treatment	$121,557,989	24.8%	$221,897,283	24%
Prevention	$26,994,593	5.5%	$231,240,326	25%
Harm reduction	$6,902,376	1.4%	$147,152,935	16%
Total – proactive spending on illegal drugs	**$489,468,763**	**100%**	**$934,304,349**	**100%**

This funding would double government spending on drug policy in New Zealand and would result in a proportion of government expenditure of 0.6 per cent, equivalent to $181 per person. This investment is still significantly less than the estimated $1.9B of drug-related harm per year (National Drug Intelligence Bureau, 2024).

There are multiple avenues that could be considered for funding this, including, but not limited to, proceeds of crime, or excise tax from legal drugs, including alcohol. Proceeds from crime returned $141 M over the last five years, after costs were deducted (Sharpe, 2025) and almost $1.2B is collected annually in alcohol excise tax (Treasury, 2025).

Under this this proposal, the current funding on law enforcement would not be reduced. Indeed, organisations like NZ Police, Customs, and Corrections may also increase the work they do under other drug policy domains (e.g. prevention).

While it would be possible to maintain the total amount of funding at current levels and reallocate it proportionally, based on community preferences, this report does not recommend doing so. Such an approach would be incompatible with the current legal settings, under which law enforcement activities will continue to require significant investment.

If drug laws were changed in New Zealand, this would alter the funding allocations. For example, in a decriminalisation model, it would be expected that less would need to be spent on court costs and corrections. If legal regulation was used for lower-risk drugs, for example cannabis, then excise tax from these legal sales could also be used to contribute to funding drug policy responses.

It is also important to highlight that the drug policy pillars are not independent of each other; for example, a significant investment in prevention would result in a longer-term reduction in the amount of money needed for treatment.

Recommendation 2 In line with stated community preferences, the Government should develop, implement, and comprehensively fund an evidence-based drug prevention programme for New Zealand. This should take a systems approach and include interventions that are specific to drugs, as well as universal interventions that strengthen individuals and communities.

Rationale for Recommendation 2

In New Zealand there is strong and unanimous support for prevention. When comparing polling data across different population groups, the preferred funding for this policy domain was nearly identical. Currently, prevention receives 5.5 per cent of funding; New Zealanders want this to be 25 per cent.

This research demonstrated that, regardless of a person's gender, voting preferences, or previous drug use, a significant investment in prevention efforts would be well-received and supported near universally across the New Zealand population. This would also be consistent with the Government Policy Statement on Health, which includes in its vision that "25% of mental health and addiction investment is allocated towards prevention and early intervention" (NZ Government, 2024).

This prevention focus would also be consistent with other current Government projects. For example, the Ministerial Advisory Group on Transnational, Serious and Organised Crime recently

published a report calling for a coordinated and integrated prevention approach, asserting that "done well, a prevention-led approach within communities is far more cost-effective than an enforcement only approach" (Ministerial Advisory Group on Transnational, Serious and Organised Crime, 2025).

The UK Advisory Council on the Misuse of Drugs recently released a significant report and call for action to implement an integrated and whole-system response to drug prevention (UK Advisory Council on the Misuse of Drugs, 2025). Their primary recommendation is that:

> the UK Government considers the funding of a comprehensive, appropriately funded, evidence-based national drug prevention programme. The benefits of such a programme have the potential to expand beyond reductions in drug use, leading to improvements in health, wellbeing, and life chances. (UK Advisory Council on the Misuse of Drugs, 2025)

The report recommends a mix of interventions that would impact prevention at multiple levels.

It is important that prevention in New Zealand is evidence-based and, therefore, broader than education. A prevention programme would need to include interventions designed to address the determinants of health, including poverty, marginalisation, and poor mental health.

For New Zealand, this would mean consideration of interventions that strengthen communities and individuals, in order to reduce demand for drugs and build resilience against organised crime and act on the determinants of health.

Recommendation 3 In line with stated community preferences, the Government should develop, implement, and comprehensively fund an evidence-based harm reduction programme for New Zealand. This should be done by expanding existing harm reduction services, and funding new harm reduction services, to create an integrated system.

Rationale for Recommendation 3

There was a significant gap between actual spending and community preference for funding allocations relating to money spent on harm reduction. Currently, harm reduction receives 1.4 per cent of funding; New Zealanders want this to be 16 per cent.

This is not unexpected, as harm reduction receives a similarly small proportion of funding in Australia (Ritter et al., 2024), and globally there is a significant harm reduction funding gap (Harm Reduction International, 2024). However, harm reduction programmes provide a significant return on investment. For example, it has been estimated that the New Zealand needle exchange programme provides $6 of benefit for every $1 spent (Keen, 2021).

While New Zealand has some harm reduction initiatives, including the needle exchange programme, legal drug-checking, and some access to naloxone (an opioid overdose reversal medicine), these all need expanding to maximise their uptake and potential benefits. In addition, there are a number of harm reduction initiatives used in comparable countries that New Zealand does not have access to, including supervised drug consumption facilities (used to prevent overdoses and provide wraparound health and social services). These have been shown to be effective and are available in countries like Australia and Canada.

Increasing access to harm reduction services will be particularly vital as the global drug supply becomes more volatile and the supply of synthetic opioids continues to increase (United Nations

Office on Drugs and Crime, 2025). Other countries, including the US and Canada, are seeing significant deaths from unintentional overdoses, and New Zealand is highly under-prepared for this potential public health crisis (New Zealand Drug Foundation, 2023).

Recommendation 4 A Citizens' Assembly on the issue of illegal drugs to be held in New Zealand, consistent with the conclusion reached during the deliberative workshops that were held. Planning for this should begin immediately, with a commitment to holding it within the next two years. The Citizens' Assembly should be given a broad mandate to consider drug laws, policies, and funding allocations at a systems level. This should be funded by the Government. The objective would be to seek cross-party commitment to act on the findings and recommendations that arise from this deliberative democratic process.

Rationale for Recommendation 4

Drug policy settings in New Zealand have been largely unchanged since the early 1960s. The Narcotics Act 1965 was developed in response to the 1961 UN Single Convention, and was passed rapidly, with little public consultation. This legislation and approach informed the development of the Misuse of Drugs Act 1975, which is still in place today. When New Zealand's drug policy settings have been reviewed against the evidence, and public consultation has occurred to elicit community views, the outcomes of these inquiries and reviews support a move towards a health-based approach to drugs. However, citizens' views and priorities are not acted upon, and are then not reflected in current policy settings or funding allocations.

These findings provide a strong argument to conclude that current policy settings and funding allocations are not only out of step with the evidence, but that they also do not reflect the will of the people. This report presents evidence that the views of New Zealanders support more investment in a health-based approach.

A deliberative group learning process was used in this project as an example of how New Zealand could move past this impasse and develop better drug policies. Those involved in it reported that they greatly valued the process of learning more about drugs and drug policy, and the group's deliberative learning process changed their views. The group was able to develop a consensus statement, which was strongly health-based and which reflected its conclusions about funding allocations and what would constitute a better drug policy for New Zealand. This highlights the value of a deliberative group learning process.

Methods

Drug budget

Costing method

A top-down costing approach was primarily used, where possible. This is consistent with the recommended approach by the European Monitoring Centre for Drugs and Drug Addiction and is consistent with the Australian drug budget (European Monitoring Centre for Drugs and Drug Addiction, 2008; Ritter et al., 2024). The challenge with costing drug-related activities is that they are rarely identified as a budget line item, and agency funding is typically not provided to just respond to illegal drugs. Therefore, a top-down approach is used, which begins by estimating costs at the highest level, and then identifying a meaningful proportion for drug-specific activities, in order to calculate a percentage of the total expenditure. The limitations of a top-down approach are that estimates are less precise, and it does not provide detailed expenditure breakdowns by activity. This is as opposed to a bottom-up costing approach that relies on identifying individual programmes that use resources and then aggregating these. For some domains, particularly harm reduction, a top-down approach cannot be used due to information availability. There were also instances where a particular activity needed to be moved to a different domain and, therefore, a bottom-up approach was used to account for this movement. This is identified where applicable.

It was not possible to create a top-down estimate for harm reduction, because it was not possible to define an appropriate proxy by which to estimate the proportion of budgets that should be allocated to this policy area. Therefore, the funded harm reduction programmes were identified and funding figures obtained for those. This does however create uncertainty when comparing the harm reduction pillar with the other three, because the estimation method is inconsistent. Top-down estimates are typically higher than bottom-up estimates (Ritter et al., 2024); therefore, it is possible the harm reduction proportion has been comparatively under-estimated.

Activities included

The activities list (Appendix 3) and specific assumptions were sense-checked and validated through consultation with experts working in New Zealand. The authors of the Australian Drug Budget were also consulted to discuss modifications to the method and where assumptions may or may not be appropriate in the New Zealand context.

By focusing on proactive spending, some activities are excluded. This includes blood-borne virus prevention, as it is considered as a consequence of drug use and thus reactive spending. It also excludes activities that are likely to indirectly impact drug use, but do not have this as a clearly stated objective. This includes programmes that are intended to modify the social determinants of health, e.g. social housing or social welfare benefits.

By using a top-down costing method, some activities that cross multiple domains are put into the domain of the primary funder. For example, the provision of drug treatment or harm reduction in prisons will sit within the corrective services sub-domain, because that is how it is funded, and was difficult to separate out as a singular programme, which would enable its costs to be moved.

Data sources

The primary data sources were publicly available funding documents from annual reports, Government reports, or budget announcements. All data sources are included in the bibliography. For consistency, budget announcements were primarily used for the total amount of funding within activities. This presents a risk that the actuals were different from what was announced. However, this provided the most consistent information source and meant any inaccuracies would be common across domains, rather than using a mixture of planned and actual spending.

Assumptions

The assumptions made for each activity are documented alongside the funding figures, for ease of comprehension.

Limitations

There is an overarching limitation in the definition of the pillars, and some activities could be argued to sit across multiple pillars. For example, the National Drug Intelligence Bureau (NDIB) provides information to support High Alert, which is a form of harm reduction. But this is not their only function, and they also support customs and policing activities. The approach taken was therefore to situate this within the domain that it is funded through, i.e. the top-down costing approach for policing will include the funding for NDIB. This issue particularly impacted the policing and corrections sub-domains, because they conduct activities that also could fit within prevention and harm reduction. Where possible, to support analysis if future studies wanted to take a bottom-up approach to cost estimation, OIA requests were made about the costs of specific policing programmes. Results from these are provided in Appendix 1.

For the law enforcement domain, the following limitations are identified:

- The Australian drug budget calculates routine policing using offence data, but notes a limitation of that approach as it may not correlate with resource allocation and excludes diversions and cautions. Additionally, their real recurrent expenditure figure needs to be adjusted to account for traffic safety expenditure that is not accounted for in offence data (Ritter et al., 2024). Therefore, proceedings data were used, rather than offence data, but this then assumes that proceedings related to drugs are similarly represented across the different proceedings outcomes (as this will influence the time and therefore resources spent).
- For court prosecutions, no data on trial length could be located, which would enable a top-down costing. Therefore, an alternate bottom-up cost-per-finalisation method had to be used. It was not possible to calculate whether cost-per-finalisation differed between court types (i.e. whether or not the drug courts have a different cost); therefore, it had to assume the cost-per-finalisation was the same across court types.
- For community corrections, adjustments were made by order length; however, a significant proportion of these were unrecorded, and the proportion unrecorded differed between drug and total community corrections orders. This introduces uncertainty into the adjustment factor, which could not be accounted for.
- It was not possible to cost treatment conducted in corrective settings; therefore, this is within the overall corrections funding and sub-domain.

For the treatment domain the following limitations are identified:

- It is possible that there were residual COVID-19 pandemic effects in the healthcare system, which may mean there were fewer face-to-face services provided, which would influence the cost of treatment provision.
- There were difficulties in calculating the proportion of people seeking treatment for illegal drugs, because of the potential for people to present to treatment with multiple drugs of concern and, therefore, calculations had to rely on primary drug of concern data.
- There is no dataset that accounts for treatment outside of specialist services, i.e. treatment occurring with GPs had to be estimated.
- It was not possible to locate a number for total healthcare treatment in New Zealand (i.e. the number of New Zealanders who sought any healthcare), which then had to be estimated using GP access data.

For the prevention domain, the following limitations are identified:

- For education, this assumes all schools are choosing to include drug education within their curriculum, and a robust estimate of the actual hours of drug education delivered could not be identified.
- For infancy and parental support programmes, the Australian Drug Budget uses the "proportion of persons 16–85 years of age with drug use disorders" as an approximation for expenditure dedicated to illicit drugs, assuming this "is reflective of the broad parenting and family population" (Ritter et al., 2024). However, there was not a robust estimate of the people with drug use disorders in New Zealand, and the most recent estimate of dependence was in the 2006 Te Rau Hinengaro study, which estimated 0.7 per cent of the population (Oakley Browne, 2006). Given the similarity of this figure with the treatment proportion estimate of 0.57 per cent calculated in this report, the same proportion was used across both the treatment and prevention domains for consistency.

For the harm reduction domain, the following limitations are identified:

- It was assumed the drug-checking budget was allocated equally across the three years of funding.
- Naloxone provision was excluded, as this was the year in which there was a limited trial of 'take home' naloxone, but no systematic provision. This has since changed, and would need to be accounted for, if the drug budget were to be repeated with later reference years.

Preferred funding allocations

Survey design

A representative survey was designed that included demographic indicators and questions to determine how people would like to see drug policy funding allocated, using contingent valuation to establish community 'willingness to pay' (Appendix 4). From other contingent valuation studies, it is standard to ask attitudinal and behavioural questions about the good or service to be valued, as a preparation for responding to the valuation question and in order to reveal the most important underlying factors driving respondents' attitudes towards the public good.

The survey had three 'blocks':

1. Attitudinal question

2. Willingness to pay (funding allocation)
3. Demographics

Recruitment

Ethical approval was by the University of Otago Human Ethics Committee (reference 25/0925).

The survey was delivered by a polling company, Talbot Mills Research, who conduct corporate and political research. A panel of community respondents were used, who were reimbursed for their time. The panels were provided by an external company, Dynata. Participants conducted the survey online. Consent was implied by survey completion, and participants could skip blocks of questions that they did not feel comfortable answering or answer 'unsure', without influencing their reimbursement.

The sample was nationwide and nationally representative. Interlocked age, gender, and regional quotas were used during sampling, and results then weighted to more closely match the adult population of New Zealand (from census data). All respondents were residents of New Zealand and aged over 18. Talbot Mills Research operates under the Industry Code of Practice for Market and Social Research (Marketing Association, 2022). Polling was conducted in May 2025.

Data management and analysis

No identifying data were collected from the survey, and all responses were pooled for statistical analysis. Data were initially collected by Talbot Mills Research and held on a secure server that is only accessible to Talbot Mills staff. They will retain the data indefinitely, consistent with their standard practice. For additional analyses, the data were shared in an excel file with the University of Otago. Once with the University, data were transferred to a University of Otago secure server, only accessible to the approved researchers, and will be retained for a minimum of 7 years.

Data were statistically analysed to 1) determine the overall averages of funding allocated, and 2) identify demographic and attitudinal variables that influenced the funding allocated.

Limitations

The maximum sampling error for a sample size of 1,252 at the 95 per cent confidence interval is ±2.9 per cent. There is a risk that, even though results were de-identified, results may be influenced by self-report bias, particularly as drug use is an illegal and stigmatised activity. It is important to note though that in the survey, 15 per cent of respondents reported illegal drug use in the past year, and this is highly consistent with the 2023/24 New Zealand health survey, where 15.6 per cent of those aged 15 and over have used cannabis (the most commonly used illegal drug in NZ) in the last year (Ministry of Health, n.d.).

Given it could not be expected that the general population will be familiar with the four drug policy pillars, clarity on these was provided by giving examples of what might fit under each pillar. Nevertheless, this could not be an exhaustive list of all possible activities, and it is possible the pre-selected examples and descriptions impacted on individuals' preferences.

Participatory workshops

Recruitment and participants

Ethical approval was by the University of Otago Human Ethics Committee (reference 25/1072).

For this component of the project, a non-representative convenience sample was used, as this component focused on the processes of change for individuals, as well as group consensus. Recruitment was conducted through U3A Riccarton. University of the Third Age (U3A) groups are common nationally and are made up of retirees in local areas who are interested in lifelong learning. As such, they host events like speakers from universities, discussion groups, and activity groups.

Dr Crossin was a guest speaker for U3A Riccarton (who have several hundred subscribed members who meet weekly) on 18 July 2025. At this lecture, and in the associated U3A newsletter, interested members were asked to stay on after the talk for a subsequent information session about this project. At this time, goals and methods were explained and contact details provided, as well as information sheets and consent forms for potential members to read. The final group was made up of 10 members of U3A Riccarton; there were seven females and three males, and participants had an average age of 77 years.

Workshop design

Participants were given the opportunity to attend seven in-person discussion groups, which occurred before the weekly U3A meeting in July–Sept 2025, and were held at the same venue. These lasted 60–80 minutes per week. The purpose of these were to learn more about drug policy, including but not limited to supply reduction (law enforcement), treatment, prevention, and harm reduction. In keeping with principles of participatory democracy, the exact topics for discussion were decided by the group and then facilitated and arranged by Dr Crossin. This included activities such as discussions with other expert guest speakers, reading and discussion of journal articles, and reviewing reports. Group members were sent pre-reading materials for each session, prior to the discussion. For participants, attendance at every week was not mandatory, but attendance was recorded, as this was the activity that was hypothesised to influence individual views and group consensus. Attendance was high, with most participants attending all sessions.

Outcomes

Group participants were asked to do three things:

1. Complete a short survey about their individual views on ‘willingness to pay’ for drug policy options before and after the completion of the deliberative learning processes (see Appendix 4). The survey was linked by individual using a de-identified code, and no names were recorded on the survey. The age and gender of group members was recorded for aggregated demographic reporting, but no other demographic details were collected from Block 3 of the survey.
2. Participate in group discussions that may (or may not) lead to a group consensus on preferred funding allocations.
3. Participate in a closing (debrief) focus group discussion, the purpose of which was to understand what influenced any change in views, and the experience of trying to reach group consensus. This followed a semi-structured discussion guide (Appendix 5), which was subsequently transcribed and thematically analysed. Individual quotes were used to illustrate key themes, but all identifying information was removed.

The data recorded were the two de-identified surveys, the group consensus decision, and the final focus group discussion. For the deliberative workshop discussions, these were not audio recorded. The subject matter presented was documented (e.g. that the group heard from a guest

speaker from a particular organisation or had discussed a particular journal article), but not the details of the discussion that occurred within the group.

Limitations

The group was non-representative, and it is plausible that there could be differences between population groups and demographics, including geographical differences. However, the polling data are nationally representative and, therefore, it was the change in views for individuals and their experience of the group-learning process that was of value, rather than the absolute funding allocations. In saying that, the group's views at baseline tended more towards a health-based approach to drugs than the general population, and it would be particularly valuable to conduct a similar process with a group who had views more aligned with a criminal justice approach at the outset.

The group was also constrained by time and, therefore, could not explore all topics of interest. The group prioritised how to use their time, but would have preferred to continue discussions and learn more, which could not be scheduled within the time allowable.

As with all groups, there was the possibility for some voices and views to be more strongly expressed than others, though this was mitigated by facilitating the group discussions and creating opportunities for all group members to speak.

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Appendices

Appendix 1 – Information from Police OIAs

From OIA response IR-01-25-5526 dated 26 March 2025

The National Drug Intelligence Bureau (NDIB)
The National Drug Intelligence Bureau (NDIB) is a multi-agency intelligence unit involving the New Zealand Customs Service (NZCS), the Ministry of Health (MOH) and New Zealand Police. The NDIB provides strategic intelligence and advice on illicit drugs, potentially illicit drugs, and precursors, to support reducing drug-related harm through supply, control and demand reduction measures to range of workgroups within Police and Government agencies. The actual spend for 2022/23 was $0.701 million of which $0.134 was cost recovered from NZCS and $0.134 from MOH. NZCS and MOH each provided one member on secondment to NDIB whose salaries are covered by the respective agencies.

Drug Information and Alerts Aotearoa New Zealand (DIANZ)
Police maintains the "High Alert" New Zealand's drug early warning system. This website acts as an early warning system, identifying acute drug harm, providing evidence and understanding of outbreaks and, in some cases, anticipating potential harm. This is a multi-agency initiative operated by DIANZ. The actual spend of $0.304 million for 2022/23 was fully cost recovered from Ministry of Health/Te Whatu Ora.

Cannabis Recovery Operation
Cannabis Recovery Operation is an operation primarily focused on reducing the impacts of illicit drug harm and organised crime in our community. This is targeted on commercial large-scale operations rather than personal use or low-level offending. The actual spend of the Cannabis Recovery Operation for 2022/23 was $0.909 million against a budget of $0.985 million.

Waste Water Testing Programme
Waste Water Testing contract with ESR Limited is to identify and monitor the consumption of illicit drugs and to inform wider intelligence units on drug use and trends allowing them to effectively address the risk of drug harm. The actual spend on this contract for 2022/23 was $1.110 million.

Te Ara Oranga
Te Ara Oranga is an integrated health and enforcement approach to addressing methamphetamine harm in communities. The programme supports the delivery of tailored responses to improve health, social and justice outcomes by working in partnership with communities (iwi/hapü, NGOs etc) to design and deliver targeted and culturally appropriate support for those experiencing drug-related harm and their whānau.

The actual spend on this initiative was not separately recorded, but the requested funding in 2022/23 to expand this initiative was $0.870 million.

From OIA response IR-01-25-14721 dated 6 June 2025

The total actual spending and budget in the 2022/23 financial year for the National Organised Crime Group and Resilience to Organised Crime in Communities work programmes are shown in the table below.

	2022/23	
	Actuals	Budget
National Organised Crime Group	25,802,900	28,299,066
Resilience to Organised Crime in Communities Programme (ROCC)	1,081,654*	2,600,000**
	26,884,554	30,899,066

** The actuals for ROCC Programme does not include the costs related to personnel. It only includes operating costs directly attributed to this programme in our financial system.*

*** The 2022/23 budget for the ROCC Programme is as per the approved 2022 Budget bid.*

Police is unable to provide the actual spending and budget for the District Drug Squads as these activities are inherent within the district operations and not separately or specifically recorded in our financial system. This part of your request is therefore refused under section 18(f) of the OIA, as the information cannot be made available without substantial collation or research.

Appendix 2 – Summary of group learning workshop topics

WORKSHOP	SPEAKER	DISCUSSION TOPICS
Overview and introductions	Dr Rose Crossin (facilitator)	- First survey - Introductions and establishing aims - Discussion about what we already know about drugs and drug policy - Topics for discussion to inform speaker selection
Prevention	Prof. Joseph Boden Principal Scientist, Christchurch Health and Development Study, Dept. of Psychological Medicine, University of Otago (Christchurch)	- What are the early life / childhood predictors of drug dependence, and relatedly, what do we know about prevention from a life-course perspective? - What are some of the demographics of drug use and harm (including people who are using drugs without harm)? - What works to prevent drug use and harm?
Treatment	Prof. Doug Sellman Psychiatrist and Emeritus Professor, Dept. of Psychological Medicine, University of Otago (Christchurch)	- What does and does not work in the treatment of addiction? - How can families be involved in treatment? - Understanding addiction from a medical perspective
Harm reduction	Jason George National Harm Reduction Lead, DISC Trust	- What is harm reduction and how does it work? - How do services like the needle exchange and drug checking work to reduce harm? - What would be best practice in provision of harm reduction services? - The value of peer-based services and lived experience in harm reduction
Law enforcement	Detective Senior Sergeant Phil Sparks NZ Police	- How are drugs coming into New Zealand? - What is being done to reduce drug supply into NZ? - The role of organised crime (national and international) - What works to minimise drug supply?
Consensus building	Dr Rose Crossin (facilitator)	- What have we learnt to date? - What is the group consensus?
Debrief	Dr Rose Crossin (facilitator)	- Experiences of the learning process - What can be learnt for future deliberative or participatory processes?

Appendix 3 – Activities included in drug budget

Domain	Activity	Notes
Law enforcement	Customs and border control	Top-down estimation
	Routine policing	Top-down estimation, with Resilience to Organised Crime in Communities programme subtracted from total, to avoid double-counting
	Court prosecutions	Bottom-up estimation using cost-per-finalisation, due to lack of trial length data
	Legal expenses	Top-down estimation
	Corrective services	Top-down estimation
	Community corrections	Top-down estimation
Treatment	Treatment provided in relation to illegal drugs in all settings	Top-down estimation
Prevention	School-based drug education	Top-down estimation
	General prevention	Bottom-up estimation, due to only one programme being able to be identified
	Infancy and parental support programmes	Top-down estimation
	Resilience to Organised Crime in Communities programme	Bottom-up estimation, with total subtracted from routine policing, to avoid double-counting
Harm reduction	Needle and syringe programme	Bottom-up estimation
	Drug testing (checking)	Bottom-up estimation

Appendix 4 – Polling survey

Block 1: Attitudinal question

Q1. Which of the following is closest to your view, even if not exactly right:

Illegal drug use should be treated as a …

- Criminal issue where users are prosecuted and fined or imprisoned
- Health issue where most of the effort goes into minimising harm
- Unsure

Block 2: Willingness to pay

Q2. If $100 of the tax you paid each year was being spent by the Government on initiatives related to illegal drugs in New Zealand, how would you like it split up between the following things:

- Reducing the supply (e.g. customs and police resources to enforce drug laws)
- Treatment (e.g. providing treatment for people who have problems with drug use)
- Prevention (e.g. providing educational resources to stop people from using drugs in the first place)
- Harm reduction (e.g. providing services like needle exchanges and overdose prevention medicine, so that people who use drugs experience less harm)
- Unsure [Tick box]

Please note that your answers to the following questions are entirely anonymous and are only used to help inform analysis of grouped responses.

Q3. Have you ever used an illegal drug?

- Yes, in the past year
- Yes, but not in the past year
- No
- Prefer not to say
- Unsure

Q4. Which of the following apply to you? (can select multiple)

- I have been harmed by my own illegal drug use (e.g. been arrested, experienced health issues, had relationship issues with friends or family)
- I have seen a family member or friend be harmed by their illegal drug use (e.g. they have been arrested, experienced health issues, had relationship issues with friends or family)
- I have been harmed by someone else's illegal drug use (e.g. been stolen from, been assaulted by someone who was affected by drugs)
- None of the above
- Unsure
- Prefer not to say

Block 3: demographic variables

- Age
- Sex
- Ethnicity
- Education level
- Income
- Religion
- Party support

Note: for participants undertaking the survey as part of the deliberative workshops, they were only asked to answer the Age and Sex questions in Block 3, due to concerns about identifiability if all were requested.

Appendix 5 – Focus group discussion guide

How did your views change, or not change, through the deliberative workshop process?

What piece or pieces of information did you find most impactful to your views?

How did the process of group learning and discussion impact any change to your views?

If consensus wasn't reached: What was difficult about reaching consensus? Would additional information and/or time have made it more likely you could reach consensus?

If consensus was reached: What was easy about reaching consensus? What part of the learning process most enabled your ability to reach consensus?